

DOCUMENT RESUME

ED 269 665

CG 019 050

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TITLE The Production of "Everything You Always Wanted to Know about Anorexia and Bulimia, but Were Afraid to Ask".
PUB DATE Jan 85
NOTE 194p.; For a related document, see CG 019 031.
PUB TYPE Reports - Descriptive (141) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC08 Plus Postage.
DESCRIPTORS *Anorexia Nervosa; Body Weight; *Bulimia; Eating Habits; *Information Dissemination; Information Needs; *Lay People; Mass Media; Publications; *Resource Materials

ABSTRACT

This report describes the research study involved in developing a document on anorexia and bulimia for the lay population. Chapter I focuses on the basic areas that provided the foundation for the study: (1) the definitions of specific eating disorders; (2) the role of the mass media in affecting anorexics and bulimics, and in educating the public about the etiology, nature, prevention, and treatment of eating disorders; and (3) the need for a publication that would answer commonly asked questions about anorexia and bulimia. Chapter II provides a review of the literature about anorexia and bulimia. Included are sections on psychological factors; social factors and a feminist perspective of related eating disorders; treatment modalities; and a summary and conclusions. Chapter III describes the 12-section survey which was developed from the literature review to identify the most frequently asked questions about anorexia and bulimia and which was completed by 210 respondents. Chapter IV presents the lay publication "Everything You Always Wanted to Know about Anorexia and Bulimia, but Were Afraid to Ask" which resulted from the literature review and survey. Included are sections on basic terms (anorexia, bulimia, bulimarexia), physical symptoms, psychological aspects, the role of the family, environmental factors, social factors, medical issues, habits and behavior, treatment approaches, educational and self-help programs, the question of sex, and history. This chapter ends with a list of suggested readings. Chapter V considers routes of distribution for this publication. The survey questionnaire, cover letter, and a set of additional questions raised by respondents are appended. (NB)

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THE PRODUCTION OF "EVERYTHING YOU ALWAYS WANTED TO KNOW
ABOUT ANOREXIA AND BULIMIA, BUT WERE AFRAID TO ASK"

MARC ZIMMER, PH.D.

JANUARY 1985

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ABSTRACT

This study of the nature, etiology, and treatment of anorexia and bulimia has been based on two major areas of research: existing literature, and questions presented by the public. The literature review investigated these eating disorders on the basis of the diagnostic criteria established by DSM III, for each disorder, respectively. DSM III indicates the following preconditions for diagnosis of anorexia: distorted body image; fear of obesity; minimum 25% loss of original body weight; lack of finding for other physical causes explaining precipitous weight loss; anti-social behavior, either through acting out overtly, or through avoiding age-appropriate social interaction.

DSM III criteria for diagnosis of bulimia are: uncontrolled food consumption; hiding binge-behavior; stopping binge eating only when experiencing physical pain, social interruption, self-induced vomiting, or sleep; extremely limited diet; frequent weight fluctuation; dependence upon diuretics, cathartics, self-induced vomiting, and/or multivariate substance abuse, including alcohol and amphetamines. Bulimics can exhibit only three of the above symptoms, and still be considered bulimic.

Given that set of definitions, the literature review was conducted to determine what information exists regarding the etiology, treatment, and dissemination of information regarding these eating disorders. A 12-section instrument was developed to survey a sample population to elicit the questions that the lay population might have regarding the history, etiology, man-

agement, treatment, identification, and prevention of these eating disorders.

To obtain the sample population, a total of 500 surveys were blindly distributed; 210 were received, which represents a 42 per cent return rate. The respondents were 30% male and 70% female. The most frequently asked questions raised by the respondents were isolated and translated into subject headings, under which all available answers have been constructed. The document covering all categories of interest has been compiled to meet the needs of a multivariate lay population. This document has been titled Everything You Always Wanted To Know About Anorexia and Bulimia, But Were Afraid to Ask, which will be distributed through public and private organizations servicing lay populations, or servicing professional populations in need of a document suitable for lay reference.

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CHAPTER I

INTRODUCTION

Preface

Eating disorders claim the quality of life, and even life itself, for thousands of victims of bulimia and anorexia nervosa. "Anorexia, bulimia, and related eating disorders claim the lives of hundreds of victims in the United States each year," (Larocca, 1984:1).

The majority of bulimics and anorexics are female, in adolescence or early adulthood, although the span of ages can include middle age, and the population can encompass men and women in a variety of racial, ethnic, religious, social, and economic groups. In addition to the physical, psychological, and social destruction experienced personally by the anorexic and bulimic, there is inestimable damage on the social network around the individual person suffering from the eating disorder. Family, friends, and colleagues can become inextricably involved in the individual's dysfunction, and the focus of all interaction can become the eating disorder.

The overarching purpose of this study is to develop a guide to understanding anorexia and bulimia, with the target audience encompassing the following populations: school professionals; parents; students; spouses of anorexics and bulimics; friends of anorexics and bulimics; other interested groups or individuals.

In order to accomplish this task, two extensive research efforts have been completed. First, there was an extensive search

of the literature, aided by data-base searches of Index Medicus, Psychological Abstracts, and Sociological Abstracts. Second, a survey was conducted to determine what target populations might want to know regarding the nature, effects, and treatment of anorexia nervosa and bulimia.

In advance of covering the process and outcomes of these research efforts, it is necessary to cover basic areas that provide the foundation for the balance of this study. These are: Eating Disorders Defined; Recent Media Emphasis on Anorexia, Bulimia, and Related Eating Disorders; The Need for a Lay Educational Document to Provide Comprehensive and Current Information in Accessible Language. The balance of this first chapter will be divided into specific treatment of each of these three topic areas.

Eating Disorders Defined

"It has nothing to do with how much you weigh. You can be so thin that your friends and family urge you to gain weight. You can have such a perfect figure that your friends tell you they're insecure around you in a bathing suit. You can be, oh, 5 or 10 or 15 pounds heavier than some chart tells you is right for your height and build. In fact, the more normal you appear, the more panicked you may be about gaining weight, and the more confused you may be about when, what, and how much to eat," (Squire, 1983:15-16).

The above description captures a number of essential pre-conditions in the development of anorexia, bulimia, or the related disorders that can propel victims to "extreme emaciation, physical debilitation, and ultimately death," if left untreated, (Rumney, 1983:ix). Anorexia nervosa, bulimia, and the newly proposed terms

of bulimarexia and bulimia nervosa are all characterized by an obsessive, profoundly destructive preoccupation with food, hinging perhaps on the individual's perception that food intake might be the single arena where he or she can exert absolute, ultimate, and final control, (Bruch, 1983).

The clinical definition can be derived from the Diagnostic and Statistical Manual of Mental Disorders Third Edition (DSM-III), which established the basic criteria for the determination of anorexia nervosa, and bulimia, respectively. However, since the DSM-III was published in 1980, a variety of other related eating disorders have been identified (Boskind-White and White, 1983).

For example, while the DSM-III notes that there is a distinct difference between anorexia nervosa and bulimia, there is recent data supporting the contention that there are individuals who suffer from combined symptoms. It has not yet been clinically demonstrated that such a disorder as "bulimarexia" is a distinct syndrome, behavior, or disorder. However, since the literature seems to reinforce the reports of those who have suffered from a combination of related disorders, it is appropriate to note here that the DSM-III (1980) criteria for the diagnosis of anorexia nervosa, or bulimia, are not necessarily the only criteria for such a diagnosis.

However, since the DSM-III does offer the foundation for clinical assessment, it will be the basis for defining anorexia and bulimia. In the Review of Literature, more insight will be offered, as the literature supports the possibility that such a

combined disorder might have certain clinically distinct characteristics, and will be described in this section, (Boskind-White and White, 1983).

DSM-III identifies five specific criteria for the diagnosis of anorexia nervosa in men and in women, although women comprise the majority of the victims. First and foremost, the client must exhibit a fundamental fear of becoming obese, despite the client's actual weight. This would mean that a 17 year-old girl, for example, might be obsessed with the fear of being obese, regardless of the fact that she is 5'5" and 90 pounds.

This first precondition for diagnosis is related to the second, which involves a profound disturbance of body image. This distorted body image reflects the fact that the victim is not just suffering from a fear of becoming obese; it means that he or she feels that obesity is a current problem, despite the fact that the scale may say actual weight is 30 pounds below normal.

The third condition leading to the clinical diagnosis of anorexia nervosa is described as follows:

"Weight loss for at least 25% of original body weight, or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%," (Larocca and Kolodny, 1983:80).

Anorexics also directly and indirectly refuse to bring their body weight to a level that is normal for their age and height. They may accomplish this goal by exhibiting confrontational behavior in their food refusal, or they may simply behave as if

they will eat, and then secretly discard the food, untouched.

Finally, according to DSM-III, a clinical finding of anorexia nervosa hinges on the lack of finding for other physical problems or disorders that might inhibit the appetite.

The criteria for bulimia are distinctly different in certain respects. First, the bulimic engages in episodes of uncontrolled food consumption, referred to as binge eating. These episodes might last two hours or more, and might involve eating exotic, high-calorie, and generally forbidden foods, such as cake, cookies, pasta, ice cream, and the like.

It is not necessarily immediately evident that an individual is binge eating. He or she will be likely to engage in three or more of the second major category of criteria that is used by DSM-III. These include: (1) eating great quantities of high-calorie, accessible food during the period of binging; (2) hiding the binge behavior so that it is not immediately evident, even when the binge is in process; (3) stopping the binge episode only after the development of stomach pain, vomiting that is self-induced, or after the individual is either interrupted by other people, or falls asleep; (4) continued dependence upon diuretics, self-induced vomiting cathartics, or extremely restricted diets filled with lists of forbidden as opposed to acceptable foods, all designed to help the bulimic lose weight; (5) frequent weight fluctuation involving approximately 10 pounds in either direction, (Larocca, 1983:81).

The next major criterion for determining the presence of

bulimia is the fact that the bulimic patient typically reports that his or her bulimic behavior is abnormal, self-destructive, and might be dominating the individual, rather than the other way around. Bulimics are typically in touch with the fact that the disorder may be ultimately managing them, and they report fear regarding the degree to which the disorder might be out of control, (Larocca, 1983:81).

The bulimic also experiences periods of intense depression following binges, and often engages in self-abusive behavior in order to exact punishment for excessive eating.

Finally, DSM-III reports that clinical diagnosis of bulimia is not related to the clinical diagnosis of anorexia nervosa, or to any other physical disorder currently known.

The definitions of these two major eating disorders vary somewhat in the literature. For example, there are those researchers who identify multivariate manifestations of anorexic or bulimic behavior as distinct disorders. Lucas (1981:No.4) distinguishes between: anorexia nervosa; bulimarexia, which involves bingeing; purging, and fasting; bulimia; binge eating; bulimia nervosa, which points to the irresistible urge to over-eat, followed by the purging behavior; functional, psychogenic, or nervous vomiting, where there seems to be no physical cause, and where vomiting is not self-induced; purging, which involves the intake of laxatives or taking of enemas in order to hasten bowel movement even when the body is not prepared to eliminate waste; vomiting, which involves the self-induced elimination of

the stomach contents, without the rest of the preconditions involved in the clinical diagnosis for bulimia.

The burgeoning literature regarding the nature, effects, symptomology, and treatment of these eating disorders is associated, in part, with the increased reports of bulimia and anorexia nervosa in a variety of populations within the United States. Anorexia nervosa, for example, "seems to have increased in frequency in the past few years, possibly because dieting is so popular, or because it is recognized more frequently. Anorexia occurs predominantly in girls at a ratio of 9:1, usually during adolescence. In males, anorexia usually occurs as a single episode, with full recovery thereafter, especially if treatment is begun early," (Larocca, 1984:7)

Given this growing population of individuals suffering from diagnosed eating disorders, it is not surprising that there has been an increase in media attention directed at exploring the etiology, nature, and treatment of such problems as anorexia and bulimia. The following sub-section will focus briefly on that media attention.

Recent Media Emphasis on Anorexia, Bulimia, and Other Related Eating Disorders

"Eating disorders are much in vogue today, and have been subject to a mixed media blitz from network programs such as "Good Morning America", "60 Minutes", and magazines ranging from Teen, Psychology Today, Dance Magazine, People, Ms., Good Housekeeping, and Science, to various medical journals, such as The British, Japanese, and American Journals of Psychiatry. All have extensively covered the hows and the whys of anorexia and bulimia," (Larocca, 1984:1).

The popular print, audio, and television media also bring the public the who of anorexia and bulimia. While featuring stories that offer specific information about the extensive, negative effects of these eating disorders, and listing places where help can be reached, the number of articles regarding the hows and whys are at least equalled by the number of articles regarding who in the public eye suffers from such an eating disorder.

A good example of this type of coverage involves the story of Cherry Boone O'Neill, who wrote a book Starving for Attention. Her story was in People, Newsweek, and other popular magazines with national readership. The readers were clearly interested in reading about the trials and suffering of this daughter of Pat Boone, the man who typifies the perfect middle-American family.

"The story of Cherry Boone O'Neill tells about her famous parents and her family's apparent stability contradicts the clean-cut, perfect image we received through the television and magazine interviews over the years. Her family was steeped in discipline, rules, family secrets, disappointments that were never openly discussed, brushes with financial ruin, and the erosion of her father's career," (Kolodny, 1983:6).

Perhaps the most valuable educational outcome of such stories is the potential to familiarize the public with the nature and ramifications of eating disorders. Drawn to read about celebrities, the public is educated in a maximally entertaining fashion. If such stories help familiarize the public with the various

problems associated with anorexia and bulimia, for example, it is possible that more people will be able to prevent, identify, or help develop treatment approaches for those who are already suffering from eating disorders, or who seem to be at risk to become anorexic or bulimic.

However, it cannot be argued that the print, radio, or television media is conducting an organized campaign to help the public understand, prevent, and approach various eating disorders, (Boskind-Lodahl, 1983; Bruch, 1973). The media present stories, and isolated information pieces, but there is no public education campaign, as there has been regarding other social, psychological, physical and education-related problems such as securing a good education, stopping smoking, driving only when sober, and understanding the need for treatment of venereal disease.

In the absence of the broad-based media campaign to help the victims and the families of those suffering from eating disorders, it is necessary to develop a readable, visually inviting publication that will help a wide variety of lay and professional people to better understand the etiology, nature, treatment, and potential effects of eating disorders such as anorexia nervosa and bulimia. The following section will focus on the need for such an accessible, basic publication.

The Need for a Lay Educational Document Sharing Current, Comprehensive Information

The essential ingredient of the publication for consumption by a wide variety of age groups, professions, and interests would

be the use of accessible, appropriate terminology and overall language. The value of a readable, information publication directed at a multivariate audience can be found in the research regarding the nature and the need for primary prevention.

"Primary prevention efforts are based on the assumption that reducing stress and giving people better resources for coping are effective ways to prevent social difficulties; so are helping them find support or professional groups and help, and developing good self esteem," (Albee, Gordon, and Leitenberg, 1983:xvii).

Low self-esteem is a primary characteristic of the anorexic or the bulimic. Guilt, anxiety, distorted body image, family dynamics, interactive relationships with adults, and a host of other circumstances and cultural messages work to promote and entrench eating disorders, compounding the low self-esteem and threatening the very life of the victims. Primary prevention efforts can certainly help to mitigate against the onslaught of preconditions that make it likely for increasing numbers of American women, and to a lesser extent American men, to become involved in eating disorders, either directly or indirectly.

The model of the publication as a primary prevention source is grounded in a tradition of literature as a way to disseminate information for public consumption. "The main tools and models for primary prevention are provided by education, social engineering, and social change," (Albee, Gordon, and Leitenberg, 1983:xvii). One purpose of the publication for a broad-based population would be to fill the gap that exists in the education component of pri-

mary prevention of eating disorders.

One of the major problems associated with efforts to educate various populations through print medium, however, has been related to the unwillingness or inability of professional educators to write their publications according to the expressed needs of the population. For example, drug education efforts might be based on the individual perception of the health education professional, rather than on the specific questions that might be posed by the target population of the education effort.

In order to assure that the publication covers the actual concerns and questions of the multivariate target population, the questionnaire that was filled out by a representative population will be used as the foundation for the book. The questionnaire was designed to elicit the specific questions that the public seems most likely to ask regarding the etiology, symptoms, treatment, and prevention of anorexia and bulimia.

The need for such a publication has been repeatedly demonstrated in the literature pointing to the alarming incidence of anorexia and bulimia (Pope et al, 1984). "The eating disorders anorexia nervosa and bulimia have increasingly become recognized as major psychiatric disorders which are common and increasing in prevalence or diagnosis among high school students and college students," (Pope et al, 1984). However, it is insufficient to simply create a document that is designed to reach the target population. It is also necessary to project and plan a method of distributing the information, once it is compiled and packaged in an attractive, professional fashion.

Both direct and indirect routes would be identified and exploited in the effort to bring the publication to the attention of two basic sub-populations: professional people, such as teachers, health educators, guidance counselors, school psychologists, school social workers, and therapists in private practice; the lay or professional population that would include the anorexics and bulimics, as well as their families, friends, spouses, and children.

Avenues of distribution could include the American Red Cross, local private and public hospitals and health centers, mental health centers, various types of public clinics, and family counseling centers. In addition, a concerted effort would be made to contact local and out-of-town in-service and pre-service teacher education programs, to make them aware of the publication and to offer literature regarding the nature and importance of this publication in the overall primary prevention efforts that have been launched from the primary grades right through to the college level.

Further efforts would be made to notify the local and specific out-of-town colleges and universities of the publication. Specific contacts would be made with infirmaries and health offices in those colleges. It is most likely that the initial contacts would be limited to direct mail and telephone contacts.

The point of this section has been to focus on the need for a useful, accessible publication designed to educate a cross-section of the population. The publications would be a means of at least partially filling the awareness gap that exists between the gen-

eral public and the victims of anorexia nervosa and bulimia.

The publication would fulfill the primary prevention imperative that has been neglected in education institutions, health and mental health problems, and families: the education of people at risk of becoming anorexics, as well as the education of people who are directly or indirectly effected by the eating disorder of a family member, friend, or colleague.

The distribution routes have already been developed in this researcher's own professional work, including appropriate contacts with national programs such as the American Red Cross, as well as such local in-service training programs as the Suffolk County Organization for the Promotion of Education. Therefore, the basic content of the book, as well as the distribution routes, have been identified in this section. There is substantial reason for projecting the effective, efficient development and distribution of a short, readable information book.

The final point regarding the content of the publication involves the decision to include case histories. Case histories of specific clients who have undergone a variety of different treatment modalities, respectively, will be covered in two ways in the publication. First, each section will begin with a statement by a bulimic or an anorexic regarding the particular question to be discussed. For example, if the question involves the symptomology of anorexia nervosa, the section would begin with a testimonial comment of a victim of the disorder. In this fashion, the publication will generate a tone of authenticity and will also capture the attention of the readers. While the voyeur in the reader might

be drawn to read about the specific problems cited in a testimonial, the reader will be learning about the disorders despite himself or herself. If this were a news story, the testimonial excerpt would act as the hook to attract and keep the attention of the reader.

The second way that case histories and testimonials will be used will be in complete sections. It might be valuable to insert the testimonials offered by a variety of those affected by the eating disorders. These case histories might include the anorexic or bulimic, the relative of the victim, the teacher, or any of a number of significant others.

Including a variety of cases involving people who are directly and indirectly effected by the eating disorder will help to assure that the reader will find a voice expressing at least some of his or her feelings, at some point in the reading and learning process.

This concerted effort to reach a variety of populations in order to contribute to the primary prevention and treatment of anorexia and bulimia will naturally be limited in scope. It can be offered independently, and can also include a supplementary video component that could offer the audience an opportunity to actually see a family discuss the problems of eating disorders, and the ways that the family went about dealing with the treatment approach chosen. The video cassette could also include a discussion by a panel of professionals who treat anorexia nervosa and bulimia, in order to enhance the treatment discussion offered in the publication itself.

The potential for a video cassette exists as a future component, if not for an immediate project. However, it is worth noting that the extensive public education campaigns that have stimulated the audience visually as well as through print media have had success in reaching a host of audiences. Certainly, if anorexics and bulimics are effected by the visual presentation of very thin women, for example, serving marvelous meals to others, and obsessing over pleasing others while feeling generally inadequate, it is possible that they might be stimulated by other visual media, as well.

Summary

This section has established the foundation for the balance of this research work by focusing on three major topics: the definition of specific eating disorders; the role of the mass media in touching the lives of anorexics and bulimics, and in educating the population at large, regarding the etiology, nature, prevention, and treatment of eating disorders; the need for a publication, perhaps enhanced by a cassette, that would answer the most commonly asked questions regarding anorexia and bulimia. The publication will be titled Everything You Always Wanted to Know About Anorexia and Bulimia But Were Afraid to Ask, and the correlation to the original sex manual is clear; eating disorders can only be helped if the conditions are understood, and pulled out of the secrecy so many individuals and families suffer.

In order to assure that maximum understanding and usefulness is achieved by the readers of the guide, it was necessary to iso-

late the most-frequently asked questions in the survey. Although this process is more specifically developed in the Methodology section of this study, it is appropriate to note that the respondents to the survey did raise a variety of questions that were very specific, individual, and unusual. Since the purpose of the guide was to answer the most commonly asked questions in order to reach the broadest at-risk population, it was necessary to choose a specific number of questions to answer.

There were respondents who raised questions that were so individual that it would be necessary for a professional to respond personally to that individual. There were others who asked many questions within one question. The treatment of the total number of questions yielded two basic types of data sub-groups: the questions raised by the majority, and those raised by the few. A list of the range of questions raised by the respondents, in both groups, is offered in Appendix C.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The onset of anorexia nervosa, bulimia, or the more newly-described bulimarexia has been correlated with a host of conditions varying in frequency and intensity from individual to individual. These eating disorders have been associated with such causative factors as distorted body image, parental pressure to diet, social and cultural milieu, a compulsive desire to achieve, a need to attain a measure of control over some aspect of the self, and rejection of sexual development.

Anorexics, bulimics, and those suffering bulimarexia might present any one or combination of the above contributing factors. Since the onset of the disorders can be precipitated by such a wide variety of conditions, there is an equally wide range of treatment modalities.

The current literature offers considerable data that helps establish current approaches to the etiology, nature, and treatment of anorexia nervosa, bulimia, and bulimarexia. The purpose of this chapter is to present a distillation of evidence regarding why women, and men, develop eating disorders, and how various treatment modalities succeed within the context of setting and causative factors.

In order to cover each major area of concern identified within the literature, this chapter has been divided into four sections:

psychological factors; social factors and a feminist perspective of related eating disorders; treatment modalities; summary and conclusions.

The psychological factors that have been positively correlated with the onset of bulimia, anorexia, and related disorders will be covered in the first section of this comprehensive overview. The second section will focus on the social conditions that contribute to the development of anorexia and bulimia.

Since the overwhelming majority of bulimics and anorexics are female, researchers have directed considerable attention to assessing what relationship exists between specific sex-related social and cultural pressures and the incidence of eating disorders among women. Literature on the subject ranges from controlled studies to philosophical essays, the full scope of which will be treated in the third section of this literature review.

The fourth section of this review covers the range of treatment modalities that have been demonstrated to be effective in curing those who suffer from anorexia, bulimia, and related eating disorders. Since the literature does not support one specific treatment approach as the definitive modality for the care of anorexics or bulimics, there has been no effort made to argue for the acceptance or rejection of any one therapeutic method. As noted earlier, the range of needs exhibited within the client population is best met through the similar range of available treatment options:

"Each one of our anorexics and bulimics is different. The only approach that can work

must take into account each patient's individuality. To date, we do not have a systematic, replicable approach to the treatment of anorexia and bulimia that works universally," (Larocca, 1984:19).

Given the complexity of causative factors linked to the development of anorexia, bulimia, or bulimarexia in a population or in an individual, multivariate treatment modalities have been tested and assessed, as is evident in the literature. The third section of this review has been developed so as to cover the dominant treatment approaches that have achieved statistically significant success in specific, reported cases.

Basically, this overview of literature has been arranged so as to present the major categories of causative factors for the onset of anorexia, bulimia, and bulimarexia, followed by a discussion of the dominant treatment approaches for these eating disorders. A fourth and final section has been added to summarize the essential points made in the current research covered in this chapter.

Psychological Factors

It is true that anorexics, bulimics, and bulimarexics suffer from a common disturbance of body image, compounded by a willingness to engage in self-injurious behavior through such painful behaviors as starvation, bingeing, and purging. However, in order to discuss the psychological conditions contributing to the onset of these eating disorders, it is valuable to consider the factors that contribute to the onset of anorexia and bulimia, respectively.

Therefore, this section has been divided into the following parts: Etiology of Anorexia Nervosa; Etiology of Bulimia; Bulimarexia: The Dual Disorder; Summary and Conclusion. In covering each of these categories separately, the shared and the distinct psychological factors contributing to the onset of related eating disorders will be discussed.

Etiology of Anorexia Nervosa: Psychological Factors

It has been repeatedly demonstrated throughout the literature that anorexics present broadly variant characteristics from case to case, (Levenkron, 1982; Larocca, 1984; Minuchin, 1978; Agras and Kraemer, 1983). However, there are certain psychological deviations that are shared by the majority of anorexics, (Bruch, 1982).

"With increasing experience in psychotherapy, it has been possible to reconstruct the antecedents of the anorectic illness, and new concepts emerged about the nature of the underlying developmental disturbance," (Bruch, 1982:1532).

Basically, what Bruch (1973;1982) points out is that the etiology of primary anorexia nervosa, characterized by deliberate self-starvation, is the overwhelming sense of powerlessness that the individual suffers. Bruch's work (1982) is directed primarily at understanding the etiology of this eating disorder as it manifests itself in women, particularly in young women, who begin their path toward anorexia with the fundamental conviction that they are ill-equipped to manage the pressures involved in decision-making or problem-solving.

Most of the young women who become anorexic have histories characterized by academic success, social competence, and an overall impetus to bring gratification to parents, teachers, and other significant adults in their lives. On the face of it, the progression toward anorexia is marked by a dramatic behavioral change, as noted below:

"The onset of anorexia is accompanied by marked changes in behavior, and previously compliant children become negativistic, angry, and distrustful. They stubbornly reject the help and care offered, claiming not to need any, and insisting on their right to be as thin as they want to be," (Bruch, 1982:1533).

Essentially, the progression from the choking sense of helplessness to the fully involved anorexic state is marked by the anorexic's panicked effort to attain a measure of control over what is happening around her. She is able to ascertain that her body is the single domain over which she can assert some control, and succeed. Since control has eluded her, and since she has defined the substance of her life according to the demands and standards of others, she can begin to derive extraordinary gratification in taking control over her physical self, (Bruch, 1973; Bruch, 1982, Crisp, 1980; Crisp, 1983; Levenkron, 1982).

This capacity to take control is the first gesture that this particular young woman might ever have made toward accomplishing the separation of self from others. The anorexic's childhood is typically characterized by a lack of experiences that could confirm her separate and positive body identity.

"The lack of regular and consistent appropriate responses to

personal needs deprives the developing child of the essential groundwork for body identity," (Bruch, 1982:1533). The child can therefore develop profoundly disturbed perceptions regarding self-other parameters, confusing gratification of self with gratification of others, and generally failing to achieve the sense of well-being that emerges in the process of healthy human development.

Perceptual disturbances regarding self-other limits can become manifest in anorexic behavior, as the individual becomes obsessed with the sense of being entirely controlled by outside forces. The anorexic makes the conscious or sub-conscious decision to dominate body urges and set the limits of self by "the counter-phobic efforts of self-starvation,:" (Bruch, 1982:1534).

Predictably, the onset of anorexia nervosa is often during adolescence, when the physical self literally takes off in a host of directions, rendering the developing adolescent a veritable stranger to himself or herself. The young woman, for example, who is a candidate for onset of anorexia, will find the changes an anathema: puberty is not an exciting opportunity, but further evidence that life is an unending series of events that demand competence and independence. With disturbed self-other perceptions, and absolutely no confidence in her ability to tackle the range of new problems and situations that emerge with puberty, the anorexic will focus all of her considerable energy on remaining pre-pubescent.

The pre-pubescent period is one typically characterized by compliance, harmonious family relations, and the care-free existence

young children enjoy. Crisp (1983) argues that anorexia is the one condition that can assure the developing adolescent of freedom from the menstrual cycle, the development of 20 per cent body fat, and the accompanying social demands that come to bear as adulthood nears. The anorexic rejects the pressure of society for him or her to become an independent, sexually competent, emotionally independent adult obligated to survive in a world of little social structure.

"Anorexia nervosa is the ultimate illustration of psychosocial need completely overriding the normal biological set point mechanisms of mature body weight," (Crisp, 1982:937).

Using Piaget's model of human development, it is possible to achieve further insight into the psychological preconditions that foster the onset of anorexia nervosa. The individual is faced with the demands of adolescence, including the maturational stage characterized by abstract thinking, moral judgement, and evaluation of presenting problems. The anorexic enters the pre-teen and teen years in the same basic stage of development that was appropriate for the elementary school-age child. This is Piaget's stage of egocentricity, marked by the child's interest in securing approval from others, and in addressing problems from a pre-conceptual, concrete level of development, (Bruch, 1982:1535).

"They continue to function with the morality and the style of thinking of early childhood. The next step is conceptual development, that of formal operations, characteristic of adolescence, associated with the ability to perform new abstract thinking and evaluation, is deficient or completely absent in anorexics," (Bruch, 1982:1535).

The anorexic rejects the separation process that is part of adolescence. She does not feel the same sense of infringement, dominance, and irritation with parental oversight that are typical of other adolescents. The potential for independence at the end of the adolescent phase is what frightens her most; she is wholly focused on achieving and maintaining a child-role in her family system, (Sitnick and Katz, 1984).

"It has been speculated that anorexia nervosa is a rejection of adult femininity (in many cases), a refusal to accept the inevitability of sexual maturity. The usual absence of this syndrome as a clinical entity prior to the onset of puberty, the inevitable amenorrhea, and the retardation of secondary sexual characteristics consequent to the emaciation may be related to psychosexual immaturity and conflict," (Sitnick and Katz, 1984:82).

The young girls at risk of anorexia have childhood histories that are remarkable in one fundamental respect: they have always been managed and directed by others. They have not successfully managed the period of personal initiative so critical to defining oneself as a separate entity, worthy of attention and support in the process of individuation.

The potential anorexic approaches adolescence as a period demanding stringent, highly disciplined, desperate steps to prevent the evolving onslaught of maturation. The potential anorexic is rooted firmly in the family system, and cannot imagine separating from that family. It has been argued that they have no faith in their own ability to make even the most basic judgements regarding the impulse to eat or rest, much less make judgements regarding

any aspect of separation from childhood and family. Potential anorexics do not have any faith in their capacity to make autonomous decisions, and have no confidence or experience in choosing or following directions originating from themselves. They take each action on the basis of directions they receive from others.

Although it may seem that the combative, resistant, and intractable quality of anorexic's attitude toward treatment or care might be interpreted as a departure from the life-long tradition of taking direction from others and rejecting the validity of personal initiative, Bruch (1982) cautions therapists to understand that the resistant behavior is a further manifestation of the anorexic's inability to initiate personal life choices.

"Their rigid discipline over their eating, with the visible weight loss, gives them the experience of being effective in at least one area. The displayed defiance is not an expression of strength and independence, but a defense against the feeling of not having a core personality of their own, of being powerless and ineffective,"
(Bruch, 1982:1533).

The literature does not reflect a consensus, then, regarding the specific nature of the anorexic or the individual at risk of becoming anorexic. Although there are often broad differences between and among individual cases, there are common themes of distorted body image, lack of self-esteem, inability to discern the self-other parameters that are the basis for all autonomous and interactional behavior, and a general rejection of the biological development that are traditionally viewed as inevitable aspects of growing up. Personality development is incomplete,

and the anorexic or potential anorexic launches a campaign to hang onto the shred of childhood promised in the pre-pubescent stage of human development, (Crisp, 1980).

Anorexia nervosa does not always develop in the pre-adolescent or adolescent stage. However, the groundwork that is the basis for the development of the anorexic is settled in childhood, in the context of the family dynamic. Therefore, it is necessary to cover the literature regarding the nature of the interaction between family members in families that produce anorexics.

Bruch (1982) points out that the families of anorexics tend to be strong and hard-working. Performance and achievement is lauded, and the children are expected to follow in the footsteps of productive, assertive parents. The child's full range of physical needs and wants are satisfied, but the critical point is that the child's needs and wants are defined by the parent(s) from the outset of the child's life. "Child care is excellent on one level--everything is provided for--but things are superimposed according to the parent's decisions and convictions, with little attention to the child's expression of needs and wants," (Bruch, 1982:1536).

Certainly it is not possible to say that all children who are dominated by their parents become anorexic. There are a multiplicity of social and sex-role factors that bear on the development of a tendency toward anorexia, and these factors will be treated in the follow-up sections of this literature review. However, the psychological conditions that nurture the onset of

anorexia nervosa are found in the family system. Therefore, the family system dynamics are treated in relatively brief fashion, in the following discussion of the psychological factors contributing to the development of anorexia nervosa.

When the infant is introduced into the family, the parent-child and child-family relationships revolve around the satisfaction or deprivation of the infant's needs and wants. If a child is able to express his or her frustration with various types of felt needs, then the child is able to learn how to recognize the signs of hunger, cold, heat, satisfied appetite, and other physical or emotional demands.

However, if a parent does not allow the child to signal hunger, for example, but chooses to feed the child when the parent thinks it is appropriate to eat, then the child does not develop the skill of understanding when and what hunger is. In fact, if the parent overfeeds the child, the child may fail to learn how to recognize the physical indicators of appetite satiation. This "lack of regular and consistent appropriate responses to his needs deprives the developing child of the essential groundwork for his body identity, with accurate perceptual and conceptual awareness of his own functions," (Bruch, 1982:1537).

Children who are raised by parents who define and then meet the needs of those children can have great difficulty achieving any sense of personal autonomy or separateness. "anorectic patients are deficient in their sense of separateness and feel controlled by external forces, helpless to interpret the messages delivered by

their own bodies, (Gross, 1982; Goodsit, 1983).

Even this brief literature review supports the contention that there are certain psychological preconditions and presenting problems that appear with significant consistency in anorexics, and in the families of anorexics. Controlling, successful parents appear consistently in the family dynamics of anorexics, and the anorexics consistently indicate distorted body image, weak ego function, maturational conflict, developmental and perceptual disturbances, and an overarching lack of self-esteem, (Crisp, 1983; Halmi, 1983; Gross, 1982). There are three more psychological factors that can contribute to the onset of anorexia nervosa, and each of these will be treated briefly in this section.

First, there is the mechanism for avoidance. Crisp (1983:952) argues that:

"The core of anorexia nervosa, making it unique, is the avoidance mechanism within it. Often denied, but inherent in full-blown, established anorexia nervosa, its essential characteristic is low pre-pubertal body weight maintenance rooted in fear of normal body weight and its implications to the anorectic."

In addition to avoidance mechanisms, anorexics frequently report high levels of anxiety related to food and the thought of food. The anorexic will focus all of her or his considerable energy towards achieving relief of the anxiety by reaching emotional homeostasis through the ongoing refusal to eat.

The final psychological condition typical of the full-stage anorexic is depression. It is not clear whether depression is

part of the range of conditions that contribute to the development of anorexia, or whether the depression becomes a serious factor because the individual has not eaten.

"I contradict many of my colleagues in my interpretation of the depression apparent in a patient with an eating disorder. I believe that the majority of these patients are depressed because they are hungry. Expediently administering antidepressants to anorectics and bulimics is thus a mistake," (Larocca, 1984:11).

Larocca (1984:11) quotes Bruch in support of his statement noted above, by pointing out that Hilda Bruch reported the following observation: "what her patient needed to alleviate her depression was three square meals a day. I think she was correct. If the patients were to eat (normally), their depression would vanish."

In constructing this sub-section, particular attention has been paid to the literature supporting what is called the preponderance of the data available. Each of the points made in this sub-section has been developed on the understanding that anorexia nervosa is a profoundly complex disease, confounding the best assessment techniques. It is possible that all of the preconditional psychological criteria noted above might only be significantly valid in describing the population of anorexics that seems to be emerging at this juncture in the history of Western society, and of America, in particular, (Crisp, 1983).

Just as there are distinct psychological factors that contribute to the onset of anorexia nervosa, there are separate psy-

chological factors that seem to lead to the onset of bulimia. The following sub-section will cover those specific factors.

Etiology of Bulimia: Psychological Factors

Obese and anorexic clients have traditionally presented behavior patterns that include episodes of uncontrolled eating, where enormous quantities of often high-caloric food are consumed at a single sitting, (Fairburn, 1983; Levenkron, 1982). This binge behavior is typically followed by an episode of purging, through either self-induced vomiting or abuse of laxatives, enemas, and/or diuretics.

"Bulimia is not a disease in itself but a manifestation of underlying psychological problems. Most people who have bulimia are greatly concerned with their weight and have made repeated attempts to reduce, either by dieting or using cathartics, diuretics, or diet pills." (Gross, 1982:19).

The bulimic is immediately distinguished from the anorexic in that the bulimic stays approximately within the boundaries of normal weight, with weight fluctuations that do not typically reach to the boundaries of excess characterized by obesity or anorexia, (Halmi, 1981; Gross, 1982; Stunkard, 1983).

Bulimia is often symptomatic of depression, anxiety, and/or an intense conflict over being aggressive as opposed to submissive, (Gross, 1983; Halmi, 1981). Any discussion of the psychological underpinnings of bulimia must include the social preconditions that predispose certain populations in Western society to the syndrome of bulimia.

"Thwarted aggressive drives may be unconsciously converted into binges as a means of expression. Many bulimic patients are torn between aggressive tendencies and the submissive behavior expected of women, a conflict born of early parental demands and expectations. Many little girls figuratively and literally have to swallow what is demanded of them and cannot assert their own likes or dislikes, even when they reach college," (Gross, 1982:23).

Patients suffering from bulimia are predominantly female, and typically begin to binge and purge in the teens or early twenties. It has been repeatedly demonstrated that bulimics have deeply disturbed attitudes toward eating, food, body shape, body weight, and their own capacity to assert some degree of control over their lives, (Halmi, Falk and Schwartz, 1981; Fairburn, 1982; Levenkron, 1982). In addition, the bulimic population has demonstrated "significant levels of anxiety and depression," (Fairburn, 1982:953).

Basically, the bulimic does not have the fear of being fat, or the food-phobia typically presented by the anorexic, (Fairburn, 1982; Squire, 1983). So, while the bulimic and the anorexic share similar behaviors in that they act out their conflicts and personal anguish through the mechanism of eating dysfunction, the fundamental difference lies in the approach that each takes toward food. The difference in the approach demonstrates the difference in the psychological underpinnings of the two populations.

In discussing the phenomenology of bulimia, Hudson, Pope and Jonas (1983) point out that bulimic patients present moderate to severe depressive symptoms in nearly 90 per cent of the cases.

In addition to presenting depressive symptoms, however, bulimics present a variety of anxiety disorders, including agoraphobia, panic disorders, general anxiety, obsessive-compulsive behavior, and simple phobias, (Hudson, Pope, and Jonas, 1983).

Additional DSM-III diagnoses of patients with the syndrome of bulimia include the following specific impulse control disorders: kleptomania and intermittent explosive disorders, with the majority of those with impulse control disorders outside of the eating disorder engaging in kleptomania. Finally, personality disorders, also included in lifetime DSM-III diagnoses include antisocial personality disorders, borderline personality disorders, and/or histrionic personality disorders, (Hudson, Pope and Jonas, 1983).

Halmi (1981) and Russell (1979) have demonstrated that bulimics suffer from depression, and that bulimia can be symptomatic of depression that is so profound as to make the patient suicidal. This is certainly evident in the self-destructiveness endemic to bulimia. Chronic bingeing, vomiting, laxative abuse, and general poor nutrition can be characterized as distinctly self-abusive behaviors, with potentially morbid implications, (Bruch, 1978; Halmi, Falk and Schwartz, 1981).

The psychological disorders that seem to provide the foundation for bulimia have been noted to the degree that the literature suggests, with the final exception of family dysfunction. Sights and Richards (1984) report that parents of bulimics, particularly parents of bulimic women, exhibit a range of demanding and restrictive attitudes toward their children. Some of the dominant

parental characteristics are noted below, in an effort to complete this treatment of the psychological underpinnings of the onset of bulimia.

"Families of bulimics are likely to maintain high levels of unexpressed tension. Three additional working hypotheses follow: that a great deal of marital conflict occurs in families with bulimic daughters; that sexual relationships for parents of bulimics are problematic; that parents expect their offspring to fulfill unrealized ambitions," (Sights and Richards, 1984:4-5).

In addition to the family system characterized by tension and conflict, and the DSM-III categories of disorders included above, bulimics tend to depend upon others for guidance and control, while simultaneously loathing those people for restricting their behavior and their options, (Bruch, 1973). Like the anorexic, the bulimic has no suitable internal mechanism to identify personal need or personal satiation, in respect to food or in respect to other arenas that require problem solving or judgment.

The literature suggests that the bulimic's tendency to be out of touch with her own feelings and needs, and the bulimic's demanding, restrictive family setting, necessarily lead to the hypotheses that bulimia and anorexia nervosa have overlapping causes, (Bruch, 1973; Mitchell and Pyle, 1982; Palazzoli, 1978; Gross, 1982). Although certain basic psychological problems are common to both the anorexic and the bulimic, it is self-evident that the bulimic's disturbed attitudes toward food do not include the anorexic's intense fear of fat, or the anorexic's outright

rejection of food, (Hudson, Pope and Jonas, 1983). However, the bulimarexic does demonstrate the same multivariate set of psychological disorders as the bulimic and the anorexic. A brief treatment of the psychological problems underlying the onset of bulimarexia will be offered in the following sub-section.

Bulimarexia: The Dual Disorder

"Bulimarexia has been operationally defined as habitual gorging and purging, combined with those salient dynamics that include perfectionism, obsessive concern with food and body proportions, isolationism, low self-esteem, and a strong commitment to please others, often at the individual's expense," (Boskind-White and White, 1983:20).

Essentially, the bulimarexic presents the full complement of symptoms experienced by both the bulimic and the anorexic. The bulimarexic is also clinically depressed, and can be identified as suicidal, as can her bulimic or anorexic peers. However, unlike the classical bulimic, the bulimarexic binges, purges, and maintains a body weight that is dramatically below normal. Minimally, the bulimarexic is 20 per cent below normal weight, and still thinks of herself as fat, (Boskind-White and White, 1983).

Anxiety and depression present themselves as precipitating factors and aversive consequences of the binge-purge cycle in the bulimarexic. Like the bulimic, the bulimarexic experiences intense guilt and depression over the bingeing as well as over the purging, and will feel the same physical discomfort that follows the purging of the bulimic. However, the bulimarexic suffers compounded anxiety because of his or her determination to lose weight, even

when death is imminent.

In fact, this determination to lose weight long after optimal weight has been reached is a reflection of the suicidal impulses of this population. Boskind-White and White (1983) report that "over 40 per cent of their treatment population of bulimarexics had sought earlier treatment for depression. More and more...include women who in desperation make suicide gestures and attempts. The binge-purge ritual is associated with the depressive episodes," (136).

Casper (1983:3) notes that the patient suffering from bulimarexia, otherwise referred to as bulimia nervosa, "has a higher tendency toward affective instability" than does the classical anorexic. The conceptual and perceptual aberrations and disturbances, noted by Bruch (1962;1973) in her analysis of anorexia nervosa apply as well to her discussion of bulimia.

Psychological Factors: Summary and Conclusion

It has been demonstrated that anxiety, depression, distorted body image, affective disturbance, disturbed attitudes toward food, performance anxiety, perfectionism, and repressed, restrictive family systems are among the psychological factors contributing to the onset of anorexia nervosa, bulimia, and the newly-categorized bulimarexia. In addition, the population of bulimarexics, anorexics, and bulimics experience varying degrees of conflict regarding sexual identity, sexual development, and the maturation process in general.

In each article reviewed, evidence is presented that the

dominant population suffering these eating disorders is female. The social conditions leading to the onset of these eating disorders are inextricably tied to "the economic, cultural and social factors that seem to have contributed to the unfolding of bulimia nervosa (and bulimia) within anorexia nervosa" in the post-World War II Western world. Those social, cultural, and economic factors will be discussed in the following section, with particular emphasis on the relationship between the role of women in Western society, and the entrenchment of eating disorders as predominantly female problems, (Boskind-Lodahl, 1976).

Social, Cultural, and Economic Factors: A Feminist Perspective

Throughout the literature, there is a continuous overlap between the treatment of psychological problems related to the onset of bulimia, bulimarexia, and anorexia nervosa, and the social and cultural attitudes toward women in a given society, (Bruch, 1973; Gross, 1983). It is not clear whether the incidence of anorexia nervosa, for example, has been higher since the end of World War II, or whether the clinical diagnosis of the disorder has simply become more refined, but there is substantial evidence supporting the hypothesis that anorexia, bulimia and the newly-noted bulimarexia have become increasingly problematic in the decades following the second world war, (Crisp, 1983; Gross, 1982; Boskind-Lodahl, 1976; Fairburn, 1983).

Social and cultural traditions have restricted women to specific roles where their lives have been shaped, defined, dominated, and restricted by their sex, (Miller, 1972).

"Nowadays, overweight, aging, and ill health are considered moral lapses that one ought to do something about. Since the end of World War II, Americans have become obsessed with appearances. The flat belly is all!," (Gross, 1983:ix).

Since the 1950's, American women have received a barrage of new demands regarding the obligatory feminine role. Now it was crucial to be thin, to be a good cook, to be submissive but to be sexually appealing, while somehow managing to be sexually competent. There are articles and television programs, news shows, and radio discussions, all designed to instruct women as to how they should behave, in order to be more pleasing, more receptive, more desirable, and ultimately more successful, with the measure of success taken by the degree to which the woman has made herself attractive to others -- parents, peers, and most of all, to men, (Bruch, 1974; Linder 1955; Boskind-Lodahl, 1976).

There are those who argue that women who become anorexic, bulimic, or bulimarexic are rejecting the social pressure to submit to the ideal, (Orbach, 1978). From this point of view, the onset of one of the above eating disorders would indicate that the patient has rejected the pressure involved with developing sexuality, and has chosen to remain pre-pubescent. The fact that menstruation stops as body weight drops precipitously below normal, is one aspect of the hypothesis offered by those who defend the argument that anorexia, bulimia, and bulimarexia are ways that certain women use to avoid becoming grown women.

Orbach (1978) specifically maintains that women become anorexic or bulimic because the arena of their physical body is the

only arena in which they can effect some control. The society deprives women of the opportunity to achieve equity in the workplace, or in personal relationships. Success is measured by dress size, marital status, parenthood, an ability to please others, and an overarching modesty regarding self-worth, (Orbach, 1982). As a result, modern women have developed a perspective that demands an impossible level of performance, since they "see achievement mainly in terms of what rewards it might provoke from others," (Boskind-Lodahl, 1976:348).

With a focus entirely on pleasing others, women must then become deeply anxious, since they are continually placed in a position of gauging other people's satisfaction with them, (Orbach, 1982). They are never quite sure of whether they have achieved a goal, or disappointed someone, or whether they have done a good job at trying.

"Obviously, women who grew up struggling to perfect the female role expect that perfection be rewarded by fulfillment. Their expectations are founded on what they perceive to be the expectations and standards of the rest of the world for them. It is expectation that has left the women I interviewed sadly vulnerable to rejection," (Boskind-Lodahl, 1976:348)

The pursuit of perfection can never be fulfilling, because the goal is unattainable, by definition. The most profoundly disturbing aspect of this entire scenario is that the search for fulfillment through pleasing others is doomed to failure, since the woman searching has not developed a system for identifying her own measure of fulfillment. She has always gauged her success

according to the reactions of others.

A woman's value is directly related to her appearance and her ability to provide sustenance and nurturing to others, (Orbach, 1982). Socially and culturally, women are the nurturers, regardless of whether the setting is a traditional family in the mid-west, or a non-traditional family living in New York City, any part of the southern states, or on the West Coast of the United States. "A woman's traditional role of service in the food arena is both real and a symbolic reflection of women's relation to society and family. The sexes are still legally, economically, and sexually unequal," (Orbach, 1982:23).

Contemporary society demands that women be the traditional nurturing experts on food and nutrition, while maintaining the perfect figures in order to be visually pleasing to the men who define and shape their lives.

"A situation exists therefore where a woman's focus on food and body converge in a particularly intense way. In order to be feminine, she must present an attractive picture of herself, which today means a slender profile. Food is what she gives others, but must deprive herself of," (Orbach, 1982:25).

Women's bodies are not the source of personal pride that the physical self can be to a man. Girls interpret their body image to be inextricably tied to their impression on the world, on their families, and on the opposite sex. The physical self is the packaging that is all-important in the market-place, where the woman must compete for men, for acceptance, and for work outside the home.

The multimedia assault on women regarding sexuality, weight,

and food is as continuous as it is contradictory. The social norm assumes that women convey the conventional knowledge regarding food and nutrition, but the commercials insist that women are ill-equipped to make their own decisions regarding what to feed the family. Commercial scenarios typically incorporate very slender women succeeding where others have failed, with success reached through the use of a product. "A woman's value rises with the ability to produce prettier, more economic, more wholesome, delectable meals," while at the same time remaining unreproachably thin. (Orbach, 1982:23)

Given the above-described social norm, it is reasonable to hypothesize that anorexic, bulimic, and bulimarexic women gather their strength to fight off the onslaught of womanhood, with all its contradictory and compulsory obligations. However, there is another perspective that is perhaps the most cogent and startling in the literature, presented by Boskind-Lodahl, (1976:345-346):

"Far from rejecting the stereotype of femininity--that of the accomodating, passive, dependent woman--these young women have never questioned their assumptions that wifehood, motherhood, and intimacy with men are the fundamental components of femininity. I came to understand that their obsessive pursuit to thinness constitutes not only an acceptance of this ideal, but an exaggerated striving to achieve it," (Boskind-Lodahl, 1976:346).

This perspective is a psychosocial interpretation of Hilda Bruch's work (1973), which maintains that anorexia and bulimia become manifest when women suffer from a delusion or misconception regarding their bodies, their internal needs and sensations, and their re-

lationships with others. Bruch (1974) attributes this perceptual and developmental dysfunction primarily to the psychological dynamic that emerges in the family system, with the mother as a primary source of the disorder, since the mother is the most involved individual in the care of the child. Boskind-Lodahl (1976) argues that "the feeling of not having an identity is not a delusion or a misperception, but a reality which need not be caused solely by a stereotyped protective mother but by other cultural, social, and psychological pressures, as well," (347).

The social problems and conditions that have been covered in this section are admittedly global in proportion. Societal attitudes, sex role stereotyping, sexual discrimination, cultural attitudes toward women and food, and media treatment of women are multidimensional quantities that have received substantial attention in the literature regarding eating disorders, (Bruch, 1974; Levenkron, 1978; Palazzoli, 1978; Sours, 1980).

Rogak (1984:1) starts her July/August edition of Consuming Passions with the following alert:

"Greetings! Have you seen that new Alba 77 commercial, 'Drink what the skinny girls drink'? This is only one of the dangerous ads that have recently been appearing in magazines and on the airwaves."

There is no question that the media messages are potent and significant, but there is no measure of precisely how significant their impact might be on the population of women, men, or pre-adolescents who are bombarded daily with the mixed messages regarding the optimal feminine achievements, according to the social standard.

There is a considerable premium placed on thinness, and on a woman's passivity in the face of male competence and assertiveness, but once again, it is difficult to measure the exact significance of this cultural and media message on the population of women suffering eating disorders.

It is also necessary to note that anorexia and bulimia are found in men, although on a much smaller scale. It is possible that its appearance in men might be associated with social pressures to perform certain physical tasks, such as gymnastics, modeling, or dance, but there is a much higher incidence of eating disorders among the women in these areas of performance than among men, (Bayer and Baker, 1983).

The fundamental point that emerges from a treatment of related literature covering the social aspects of these eating disorders is that contemporary views of the female role, combined with the fashion of thinness, have impacted significantly on the virtual epidemic of eating disorders that appear primarily in women. Treatment of anorexia nervosa, bulimia, or bulimarexia must necessarily involve an understanding that the etiology of the disorder could be in the continuous messages that the patient receives at work, at home, on the television, the radio, and in print media. There is a virtual conspiracy of input that can close off the patient from effective treatment, (Rogak, 1984:1-2).

Despite confounding family, psychosocial, and sexual conditions, certain treatment modalities have been effective. The purpose of the following sub-section of this study is to identify specifically those treatment approaches that have been demonstrated

as effective with male and female anorexics, bulimics, and bulimarexics.

Treatment Modalities: A History of Relative Success

It was noted in the beginning of this study that anorexia nervosa, bulimia, and bulimarexia can be precipitated by multivariate factors, with case-to-case differences in regard to the presence, frequency, and intensity of any one precipitating factor. Given these differences from case-to-case, it is reasonable to expect that a wide variety of treatment modalities might be found effective with the population of anorexics, bulimics, and bulimarexics. In fact, the literature does demonstrate that multivariate treatment approaches have proved successful in helping this population to recover from their respective eating disorders to a significant degree. Each of the dominant treatment modalities will be covered in this section.

The purpose of this section is to identify rather than to evaluate the dominant treatment techniques covered in the literature. Since this study has not included any systematic, controlled comparative analysis of the various treatment modalities, any discussion of the comparative benefit of one approach as opposed to another would be inappropriate. The order of the treatment methods noted is not meant to be interpreted as an implicit hierarchy, as are any notes regarding the effectiveness of the intervention with anorexic, bulimic, and/or bulimarexic clients.

Insight Therapy

Gross (1983:157) suggests that "one treatment modality that

shows successful results in care of bulimia is intensive, individual, insight-oriented therapy." This insight therapy can be conducted in tandem with dietary training. The argument advanced for this approach is basically that the insight will help the patient break the cycle of food abuse, since insight into personal motivation can be effective in changing a person's life. In this type of therapy, the patient can reveal the sexual, developmental, and interpersonal aspects of her own maturation process, which can help the therapist to identify what, if any, underlying conflict might exist in the patient's life. If the underlying conflict is identified and the eating disorder is understood as an expression of aggression or self-hatred, then the patient may be able to eliminate the behavior.

It is sometimes indicated that bulimics, anorexics and bulimarexics might do well if they are placed in structured settings, outside of the home, while they are receiving initial therapeutic intervention. However, the patients who initially show progress in separated therapeutic settings, such as hospitals, often fall back into their eating behaviors when they are returned to the environment that nurtured the disorder in the first place, which is the family system, (Bruch, 1973; Levenkron, 1982; Squire, 1983).

Cognitive-Behavioral Therapy

This is a variation on behavior therapy and insight therapy, and is based entirely on the conviction that the full range of eating disorders, including anorexia, bulimia, and bulimarexia,

are "indulgent behaviors," (Squire, 1983). This is the same treatment modality used with substance abuse and other addictive disorders, and involves a "combined modification of thought and action," (Squire, 1983).

Levenkron (1982) advocates for the cognitive-behavioral approach, since it involves the restructuring the patient's attitudes toward herself or himself. It is essential for the patient to be motivated to change, in order for this treatment approach to be optimally effective, (Squire, 1983:177).

This treatment modality allows the patient to struggle with the effort to gain control over the eating process, and very specifically helps the patient define the thought process contributing to the symptomology, on the assumption that the symptomology of the eating dysfunction contributes to the entrenchment of other problems, such as depression and anxiety, (Levenkron, 1982; Marlatt, 1977).

The treatment assumption is that the patient who is equipped with self-control in the arena of the indulgent behavior will be able to at least begin to effect change in her or his life. Imagining success, combined with relaxation and food consumption training, seem to contribute to the success of this cognitive-behavioral approach with specific cases.

The literature does not yield consistent percentages regarding follow-up studies of patients who have received cognitive-behavioral training. However, this treatment approach is in keeping with the findings of Crisp (1933), which demonstrate the following:

"The anorexic is phobic of adult body weight and the associated social and interpersonal demands. Thus, the goal of treatment has come to be seen as the restoration of normal body weight, which, in turn, leads to exposure to, and experience with, normal adolescent or adult social and interpersonal demands," (Agras and Kraemer, 1983:928).

The cognitive-behavioral approach does seek to moderate body weight through restructuring and thinking pattern and the relevant behaviors of the individual patient. Squire (1983) suggests that this is the optimal approach for all three populations being discussed in this study, although the milieu for the bulimic or the anorexic might be different; the anorexic might respond most completely if placed in a short-term hospital program, while the bulimic may be able to stabilize the eating behavior without necessarily entering a hospital.

As is evident throughout the literature regarding the treatment modalities and outcomes, multimodal approaches that either remove the client from the family or treat the entire family are considered optimal. The following section will focus on the family therapy models.

Family Therapy

Minuchin, Rosman, and Baker (1978) attack the problem of the anorexic in the context of the entire family. Just as the alcoholic can be identified as enmeshed in a family system that protects and reinforces the negative behavior, with the nearly-impervious family mythology used to protect all of the members from the intrusion of a therapist, the anorexic seems to emerge

from a similar family system. "Loyalty and protection take precedence over autonomy and self-realization," (Minuchin, Rosman, and Baker, 1978:59). Independence of one family member is therefore viewed as a violation of the implied family contract, with its complex interdependencies based on the assumption that the child cannot be empowered to become an effective adult.

Given that the family of the anorexic has a firmly and finely developed defense mechanism against intrusion, the family therapist must basically enter the family system and secure the trust of the family members. With that trust, the therapist can then create an atmosphere conducive to challenging and restructuring the family dynamic. Although the therapist initially takes charge of the family, he or she always makes specific points from the perspective that the individual can become empowered to take on independent responsibility in the family system and in other social settings.

One of the ways that Minuchin et al have succeeded in bringing the anorexic to eat a normal amount of food without using hospitalization is to literally focus the entire family session on food. Minuchin's approach, and the family therapy model in general, is confrontive in regard to eating disorders. He refers to the anorexogenic family, thereby removing the obligation of one individual family member to improve during treatment. Structural Family Therapy, advocated by Minuchin, has enjoyed success with anorexogenic families, and the anorexic behavior of the individual family member has been found to cease in a total of 86

percent of the cases treated, (Rumney, 1983:88). However, there are certain problems with this particular family therapy approach.

"Some therapists do not like the radical, intrusive, manipulative approach Minuchin uses. Furthermore, effective intervention in an anorexogenic family demands the skill of a highly qualified family therapist, and a less experienced practitioner may not have sufficient impact on the family system to produce remission of the anorexic symptoms or to promote the restructuring of the family system," (Rumney, 1983:89).

In addition to the fact that the modality might be limited to use on the basis of the psychotherapist's skill, there is the added point that Minuchin's success is limited to those anorexic patients who are still living at home. Stern (1981) has developed a family therapy model involving the separated family members, with the hospitalization of the patient and the treatment of all family members, together and separately. Stern (1981) offers a family-developmental model, carrying the family members through a process of five specific steps, all focused on restructuring the parenting process.

There are no specific statistics regarding the outcome of treatment for the anorexic patient in this family developmental model, and it does seem that it might be limited to serving the population of anorexics who are still living at home. However, it is necessary to note that there are three interdependent conditions that often impact on the entrenchment of anorexia, bulimia

and bulimarexia, as well as on the development of other somatically-manifested problems. Minuchin identifies these three components as follows: a family system encouraging to developing somatic symptoms; the tendency of the child to become personally involved in the marital conflict or traumatic events in the family system; psychophysiological vulnerability, (Minuchin and Fishman, 1979). Given this constellation of preconditions, family restructuring might be critical in reversing the potentially deadly effects of the eating disorder discussed throughout this literature review.

Clinical Biofeedback

"Clinical biofeedback therapy has direct application to the treatment of three main features of anorexia nervosa: disturbed body image, lack of awareness of inner stimuli, and a profound sense of lack of control. Therapy for anorectics is effective when it increases the sense of effectiveness, releases inner feeling, and corrects hypothalamic imbalance," (McKee and Kiffer, 1983:129).

Schowalter (1983) has pointed out that "probably one of the most important gains by children and adolescents from the use of biofeedback is the increased sense of autonomy and self-sufficiency," (455). From the diagnostic process through to the treatment, the biofeedback mechanism makes it possible for the bulimic or the anorexic to identify a specific arena in which to assert some individual control.

McKee and Kiffer (1983:138-139) identify a total of fifteen steps that the client must take, from the operant conditioning of the muscles, to the feedback learning, through the relaxation

exercising, and into the more complex arenas of confronting conflict with the therapist, family members, self and significant others. Insight into stress and the development of a positive relationship with the therapist can help the patient to respond to the biofeedback information, and can stimulate attitudinal, behavioral and emotional changes. "Cathartic reexperiencing and emotional release can reduce stress, and the changing focus of control takes place, so the patient can take responsibility for her or his own self-being," (McKee and Kiffer, 1983:139).

It is possible that clinical biofeedback techniques work for the anorexic, bulimic, and bulimarexic because the techniques address the primary presenting need of the patient, which is, for personal autonomy of some modicum of control. It is fundamental that the biofeedback be used as a part of a multimodal approach using relaxation stress-management, food-intake management, and other therapeutic methods.

Drug Therapy

Since depression and anxiety have been positively correlated with the onset and entrenchment of eating disorders, mood-elevating drugs have been used for in-patients as well as out-patients. Tricyclic drugs have been used frequently to combat depression, and to cut through the denial and resistance that the treatment population can present when efforts are made to identify and treat depression, (Gross, 1983). "The highly obsessive, compulsive behavior of eating or not eating is a mechanism by which the patient diverts attention from an underlying depression," (Gross, 1983:99).

Clearly, this type of out-patient intervention can be hazardous with those patients who engage in alcohol or multi-substance abuse where combinations of depressants and/or amphetamines might be attempted. The same caution is directed at neuroleptic drug use, since the neuroleptic drug family interferes with the production of dopamine in the synapses of the cells in the brain, (Gross, 1983). "Neuroleptic medications can be used for only a few weeks to help the patient accept therapy and deal with the difficulties of weight gain more calmly," (Gross, 1983:99).

In-Hospital Care

Reece and Gross argue that a "comprehensive in-hospital program that creates an optimal milieu" is the critical component of the treatment program for men and women suffering from anorexia, bulimia, and bulimarexia. In-patient treatment is efficient from the vantage point of the therapist, since the therapist has the patient in a highly controlled setting. Halmi, Powers, and Cunningham have achieved a degree of success by using behavior modification programming, which is the core of the Comprehensive Milieu Program for in-patients in hospitals, suggested by Reece and Gross, (1983). Group meetings, individual therapy, family therapy, drug treatment, and food intake supervision are all part of such a treatment environment. The problem arises when the patient must leave the controlled setting, and either live alone or with family members who have been part of the development of the eating disorder.

Group Therapy

There are two fundamental types of group therapy that the client can choose. The first is group-directed and the second is therapist-directed. Under the direction of a therapist, a group can serve to share information, impart a sense of self-worth to the new recruit, establish that others have the same problems, and can offer role modification as the members of the group adopt roles typical of their roles in their natural families, and then gradually change those roles with insight and with support.

Support is the key component that is provided by the self-help groups, such as Bulimia-Anorexia Self Help (B.A.S.H.). Self-help groups gather and disseminate information, cut through the isolation of the individual suffering from the eating disorder, and provide a forum for an exchange of ideas that would otherwise receive virtually no attention from the client or the professional population. These include self-reports, calendars of topical meetings, and book reviews for the professional as well as for the patient population.

Overview of Treatment Outcomes

Agras and Kraemer (1983) have pointed out that the same proportion of success has been reported whenever the therapeutic intervention involves the patient's distorted body image and disturbed social and interpersonal relations.

"Follow-up studies reveal that nearly two-thirds of a previously hospitalized anorexic population will be at normal weight, and the

majority of these individuals will have resumed regular menstruation. However, about half will continue to have eating difficulties and will show social and psychiatric impairment. A small number of anorexics will become obese, and between 2% and 6% will have died from complications of the disorder," (Agras and Kraemer, 1983:928).

The prognosis is extremely poor when the patient presents symptoms of weight loss that is considered severe, even within the anorexics population, where the disorder has been on-going, and where there is bulimia and anorexia in the same behavior pattern.

There is no significant data regarding the relative efficacy of any one treatment modality as opposed to another, in part because the treatment is characterized by methodological difficulties. The population is small, elusive, and not necessarily involved in any long-term follow-up studies of substantial size, (Agras and Kraemer, 1983). Certainly, controlled studies regarding larger populations would be helpful, but at present the literature does not support more than single-case and small-group data.

Summary and Conclusion

It is evident that bulimia, anorexia nervosa, and bulimarexia are complex psychological and social problems that require vigilant research and attention, if treatment is to be improved. However, it is equally clear that prevention and early intervention are the best hopes, particularly since long-term dysfunction is a part of the poor prognosis for patients who enter into therapy for eating disorders.

Prevention and early intervention are best conducted with a sound information base, provided by a reference tool that equips the lay professional reader with the information necessary to identify symptoms, or to help prevent the development of symptomology by addressing the fundamental causes, such as depression, sex role conflict, grief, and other pressures or problems. A substantive literature review constitutes a key component of a viable point of reference for lay and professional individuals seeking information regarding the definition, etiology, nature, identification, treatment, and prevention of these eating disorders. This overview of current literature has been designed to pull together the key elements of the standard, and the new, and to provide a readable resource to all those interested in achieving greater insight into anorexia, bulimia, and bulimarexia.

CHAPTER III
ANATOMY OF A DIRECT SURVEY

PART I: METHODOLOGY

Introduction

Eating disorders disrupt the quality of life experienced by the victim, and those who know and love that person. In the extreme, eating disorders are mortal illnesses, experienced primarily by women and girls who experience a range of internal and external pressures that are expressed as the eating disorder. Although obesity is certainly a condition often reflected as an eating dysfunction, this study is limited to the investigation of anorexia, bulimia, and a new disorder identified in the literature as bulimarexia.

The purpose of this study has been to survey a multivariate population, including a range of ages, religions, geographical locations, formal education levels, and employment categories, to determine what a range of lay people might ask regarding the etiology, identification, prevention, treatment, and nature of anorexia, bulimia, and bulimarexia.

The first part of this description of the survey will cover the specific survey methods. The second part will focus on the survey results.

The Survey: A Content Rationale

Two basic formats exist to solicit general questions from a wide range of people: the first is to provide large categories within which the respondent can list relevant questions; the second is to simply ask the respondent to note what questions

he or she might have regarding the subject matter. The first option was selected for several reasons.

The primary reasons for selecting the first format was that listing categories could stimulate questions that respondents might not think of on their own. For example, a respondent might not think of asking about self-help groups, because the notion of the self-help group might not be part of the respondent's store of ready information. However, listing a category for questions about such groups can help stimulate the respondent to raise certain questions about the efficacy, nature, and availability to self-help groups, such as B.A.S.H.

The second option did not offer that kind of stimulus for the respondent. Another reason why the first option was chosen was its relative accessibility in gathering the information as the surveys were returned. In the structured format, the researcher has the opportunity to refer to all of the respondents' points about habits and behaviors, for example, instead of sorting through each completed survey, looking for possible allusions to habits and behaviors.

For further clarification of the structure and nature of the instrument, please refer to Appendix A and Appendix B, respectively. Appendix A is the letter to the prospective respondent, and Appendix B is the survey itself.

How The Surveys Will Be Treated

Correlations will be drawn between the essential categories of data. That means that determinations will be made regarding

the relationship between demographic characteristics and the types of questions asked. For example, it will be determined whether adolescents have a great many diverse questions, or whether they only ask questions if they are part of an anorexic family.

When it is determined specifically what types of questions predominate, the final book project will offer answers to those questions, using information gathered in the literature review. Basically, soliciting the most often-asked questions regarding anorexia, bulimia, and related eating disorders gives this researcher a solid outline for answering those questions through a readable, up-dated resource for the full range of interested and effected populations.

PART II

Results

The results of this study demonstrate the validity of the research assumption: that the lay and professional population perceive a need for a lay-oriented, readable publication that addresses specific, common questions regarding eleven basic aspects of the etiology, nature, and treatment of anorexia nervosa, bulimia, and related eating disorders. These eleven categories include: (1) physical; (2) psychological; (3) family role; (4) environmental factors; (5) medical issues; (6) social factors; (7) habits and behavior; (8) treatment approaches, both psychological and medical; (9) historical perspectives; (10) educational/self-help models and resources; (11) sexual aspects. The literature formed the basis of determining major categories in understanding A/B.

In addition to responding to the questionnaire (see Appendix A) eliciting specific questions regarding the respondent's concern about related eating disorders, the questionnaire included a set of questions regarding the socio-economic and religious group to which the respondent belonged.

Given these two categories of data, this section has been divided into a discussion of each group of data, respectively, followed by a discussion of the relationship between the questions posed by the respondents, and the socio-economic and religious group status information that emerged from treatment of the data.

TABLE OF COLLECTIVE NUMERICAL DATA

N = 210

SEX

MALE

63 (30%)

FEMALE

147 (70%)

AGE *

MALE

40.3

FEMALE

36.2

* (Average)

EDUCATION

MALE

H.S. --
COLLEGE 27 (42.8%)
MASTERS 24 (38.1%)
ABOVE 12 (19.0%)

FEMALE

42 (28.0%)
60 (40.8%)
30 (20.4%)
6 (4.7%)
BELOW H.S. 9 (6.1%)

GEOGRAPHICAL LOCATION

MALE

N.Y. 27 (42.8%)
L.I. 12 (19.0%)
NEW ENG. 3 (4.7%)
N.J. 9 (14.2%)
INTERNAT. 6 (9.5%)
MIDWEST 6 (9.5%)

FEMALE

90 (61.2%)
24 (16.3%)
9 (6.1%)
21 (14.2%)
3 (2.0%)
--

OCCUPATIONAL STATUS

MALE

PROFESS. 42 (66.6%)

FEMALE

51 (34.6%)

TABLE OF COLLECTIVE NUMERICAL DATA - 11

OCCUPATIONAL STATUS - CON'T.

	MALE		FEMALE	
NON/PROF.	15	(23.8%)	84	(57.1%)
STUDENT	3	(4.7%)	12	(8.1%)
RETIRED	3	(4.7%)	--	

RELIGION

	MALE		FEMALE	
NONE	12	(19.0%)	15	(10.2%)
JEWISH	21	(33.3%)	75	(51.0%)
CATH.	21	(33.3%)	51	(34.6%)
PROT.	3	(4.7%)	3	(2.0%)
OTHER	6	(9.5%)	3	(2.0%)

The results of the first group of data, encompassing the full scope of questions posed by the respondents, is treated implicitly in Chapter IV of this study. Chapter IV comprises the complete publication that will be titled Everything You Always Wanted to Know About Anorexia and Bulimia, But Were Afraid To Ask. Since it is organized specifically around the questions posed by the respondents, it would be redundant to include a list of those questions here.

Suffice to say that final publication represents two major types of questions: those that were posed most frequently by the respondents; those that were insightful and important, but that did not appear very often in the questions listed by the respondents. For further clarification, please refer to the Table of Contents and the text of the publication itself in the following chapter of this study.

The second major category of data that emerged established what is best described as a statistical picture of the population of respondents. This statistical picture was developed through an analysis of the cumulative data regarding the following characteristics of the respondents: age; sex; religion; education; profession/occupation; geographical location.

In order to establish the collective significance of the information regarding the above characteristics, each of the following categories have been treated separately: Age and Sex; Religion; Education; Profession; Geographical Location. A final sub-section has been added, to cover the implications of the analysis of this particular set of demographic data, in relation to the socio-

economic considerations that are part of the overall study of the nature, etiology, and treatment of anorexia nervosa, bulimia, and related eating disorders.

In advance of the discussion of the specific demographic data, a short preface to the data analysis has been added, in order to establish the size of the sample surveyed, as well as the percentage of the sample that responded to the questionnaire.

The Sample. The sample population was chosen through a blind process, from a variety of sources noted in the Methodology section of this study. The total number of surveys sent out was 500. Out of the 500 surveys that were distributed randomly, a total of 210 were returned. This total represented a solid 42 per cent response rate, which indicates that the sample population was sufficiently interested in the topic to respond at a rate exceeding the response to most mailed surveys that have no specific follow-up procedures or constraints that were designed to encourage response. As noted in Huff (1954), 20 - 30% response rate is considered desirable.

Age and Sex.

N = 210

SEX	NUMBER	PERCENTAGE OF SAMPLE
F	147	70%
M	63	30%

Clearly, the blind selection of respondents yielded a pre-

ponderance of female respondents.

Since an equal number of surveys was sent to males as to females, the percentage of female as opposed to male respondents completing the survey was a result of the response made by the population, and not by the distribution method.

In addition to protecting the validity of reliability of the survey by distributing the questionnaires equally to men and to women, further protection was assured in the method of contacting the individual members of the population. There was no personal contact between the researcher and the surveyed population, beyond the cover letter that was attached to the survey. The cover letter was identical for male and female respondents.

Given this set of precautions, it is evident that there was no halo effect, and no personal impact of the researcher upon the sample population, in terms of the willingness or interest of men or women to respond to the survey in greater or lesser numbers.

AGE OF SAMPLE

MALE	FEMALE	COMBINED AVR.
40.3	36.2	37.4

This average reflects a broad range of ages, from a high of 64 to a low of 15 years. However, the dominant number of respondents fell within the age group of late twenties to late thirties and early forties. This is related to the fact that the majority

of respondents were already out of school and in the workplace, as is evident in the discussion of occupational status, noted below.

It is possible that the distribution of surveys to the student population was insufficiently structured. Although the survey was distributed in such a manner as to assure that an equal number of men and women in each category, including students, were selected for surveys, it is possible that students require more reinforcement or reminding in order to elicit a significant response from that particular sub-group.

If students require proportionately more numerous or repeated contacts than the general adult population, there is no literature that indicates how such a proportionately heavy distribution or contact methodology should be constructed when the goal is to survey a cross-section of the overall population. Given the lack of such specific direction in the literature, the researcher chose to follow the basic procedures that protect the validity, reliability, and equity of a given survey: to distribute the survey equally among all sub-populations in the overall sample population. Therefore, the degree to which one population responded over another sub-population was attributable to causes beyond the scope of the researcher.

Educational Background. It was necessary to determine the formal education typical of the respondents, since the literature demonstrates that the majority of the families producing anorexic, bulimic, and other similarly troubled children and young adults are generally well-educated, in terms of years spent in high school,

college, and higher education.

It was also necessary to determine if there was a positive correlation between the respondent's years of formal education, and the nature of the questions asked. If, for example, the majority of the respondents had received a maximum of a high school education, two imperatives would emerge regarding the content and the distribution of the final publication.

The first imperative would be to write the publication so that a non-college educated audience would be able to understand and apply the information. The second issue would relate to the distribution outcome, indicating that the majority of respondents were high school educated and not beyond would be to assure the publication distribution was directed to facilitate access to the populations with less college education.

The following chart demonstrates the percentage of respondents that fell into the major categories of formal education, broken down by male and female, and then combined to represent the full sample.

FORMAL EDUCATION

	<u>HIGH SCHOOL INC.*</u>	<u>HIGH SCHOOL</u>	<u>COLLEGE</u>	<u>MASTERS</u>	<u>POST MASTERS</u>
M	--	--	43%	38%	19%
F	6%	28%	41%	21%	4%
C	4%	29%	42%	21%	10%

(* "INC" refers to High School Not Completed)

The above table demonstrates that the majority of the respondents had completed their formal education at college or higher. Fully 73% of the total number of respondents had completed their college, masters, or post-masters education. That is a comparatively well-educated population.

Another notable point is that all of the men who responded to the survey had achieved at least a bachelor's, while 38% of the women had either earned a high school diploma, or had not yet completed their years of high school.

The actual number of respondents who had not completed high school were all enrolled in full-time high school programs, and were all teenagers. In addition, they were all girls.

Occupational Status. It is evident that the majority of the men and women responding to this survey were both educated and professional. The distribution of professional and non-professional status is noted below. One point can be made at this juncture, however: all those who noted that they were retired also noted that they were in specific professions before their retirement, including psychology, teaching and engineering.

OCCUPATIONAL STATUS

	<u>PROFESSIONAL</u>	<u>NON-PROFESSIONAL</u>	<u>STUDENT</u>	<u>RETIRED</u>
M	67%	23%	5%	5%
F	34%	57%	8%	--
C	44%	47%	6%	3%

A total of 84 individual women answered that they were non-professionals, although 38 of those 84 women had earned professional degrees. This sub-population of women had chosen to permanently or temporarily work inside the home, at the traditional task of raising children and keeping the home in order. Therefore, they considered themselves non-professional, although they had received professional education and training, and it was evident from their ages and their experience, noted in the comments section, that some of them had already been employed in the outside workforce, and had left in order to stay at home with their young or adolescent children.

The overwhelming majority of men clearly considered themselves professional people, and a substantial minority of women responding to the survey reported that they were professionals, which was an indication that they were part of the current workforce outside the home.

Those who were students had completed some high school, or had completed high school and entered college. There was only one full-time student on the masters level and she described herself a non-professional, since she felt that category best described her role as a married woman raising two children and attending school full-time.

Religion. Since the literature suggested that, in this time and in the United States, young middle and upper class women of Jewish or Italian extraction were prone to suffering from anorexia, bulimia, or related eating disorders, the religion of the respondent was found to be an important piece of information. A cor-

relation between types or content of questions, and religion, might suggest that certain religious or ethnic groups require more information and support than others. If that would be true, then once again, the content of the publication and the distribution of that guide would be effected.

RELIGION

	<u>JEWISH</u>	<u>CATHOLIC</u>	<u>PROTESTANT</u>	<u>OTHER</u>	<u>NONE</u>
M	34%	34%	4%	9%	19%
F	51%	35%	2%	2%	10%
C	46%	35%	3%	4%	12%

Fully 81% of the respondents were either Jewish or Catholic. This statistic emerged despite the fact that there was a concerted effort to distribute the surveys in communities that would collectively represent an equitable distribution between and among religions and ethnic groups.

GEOGRAPHIC LOCATION

The data that was gathered of the geographic distribution of the sample population responding to the survey indicates that the population of those who did respond to the survey was largely from the local metropolitan area. In advance of the table below, it is necessary to note that only urban and suburban individuals responded, although it is possible that those individual people were living at some point in their lives in rural communities.

It might have been more valuable to solicit income information than geographic information, but the research regarding soliciting personal financial information indicates that people frequently overestimate, underestimate, and/or such a distraction to the respondent that the issue of financial information distracts the respondent from the balance of the topic, (Huff: 1954). It was determined that the inaccuracies and the uncertainties of asking for personal financial information were not worth the risk.

The purpose of determining geographical location was to help determine the nature and the routes of distribution of the final publication. If no respondents came from the greater New York area, for example, it would be difficult to justify distribution to those areas on the basis of requests of the local, surveyed population.

GEOGRAPHICAL LOCATION

	<u>NEW YORK</u>	<u>LONG ISLAND</u>	<u>NEW ENGLAND</u>	<u>NEW JERSEY</u>	<u>MIDWEST</u>	<u>INTERNAT.</u>
M	43%	19%	4%	14%	10%	10%
F	61%	16%	6%	15%	2%	---
C	55%	17%	6%	15%	5%	2%

It is evident that the majority of the respondents came from the Northeast, encompassing New York, New Jersey, Long Island, and New England, with the majority of those responding from New England coming from Connecticut.

Clearly, those who were surveyed did come from the major metropolitan and suburban areas of the tri-state area, and so it is not surprising that the men and women who responded to the survey were part of that population. However, it can be argued that, if there were no interest expressed by the members of the sample population, they would not have responded. It is reasonable to maintain, therefore, that the percentages and the numbers of those who responded from the tri-state area reflect a substantial need for information in those areas. The following section will focus on a discussion of the survey results that have been detailed above.

Discussion

This discussion section will follow the organization of the section reviewing the results of the survey. Following a discussion of each of the major categories of data, a summary section will be added, noting what relationships seem to exist between and among the respective categories of data. The purpose of the final section of this chapter is to develop what is best described as a statistical picture of the average respondent, male and female, respectively.

Age and Sex of Respondents. The men and women who answered and returned the survey to the researcher were in their thirties or early forties, for the most part. It is possible that several factors contributed to that outcome.

First, there is the possibility that the age group noted above is simply more responsible and responsive to surveys. This is not demonstrated in the literature in any consistent fashion, but the population's attitudes toward being surveyed, and the value of

responding to surveys, is important in analyzing the results of a survey. If, for example, the population of respondents represented the least well-informed groups, then the publication would be targeted primarily at this age group, on the assumption that younger and older people basically understand the nature, etiology, and treatment of the eating disorders covered in this study.

However, that would be a fallacious assumption. The researcher prefers to approach the average age and distribution of male-female data from the following perspective: those who were most responsible and most alert to the potential dangers posed by such eating disorders as anorexia nervosa and bulimia were those who responded to the survey. In addition, it is reasonable to assert that their response to the survey was an indication of their conviction that responding would ultimately contribute to a substantive, useful outcome, (Huff, 1953).

Therefore, despite the fact that the men and women who responded to this survey fell into the over 30 category, the full range of population groups, including high school age, junior high school age, and college age students and young adults will be targeted when distribution of the publication is routed.

The reasons why the full range of age groups targeted will be kept intact is that the literature supports the contention that the young women on the lower end of the age spectrum tend to be more at risk of developing anorexia nervosa, bulimia, and related disorders. If young women, the young men who they date, and their families, teachers, and full complement of significant others grasp

the nature and treatment of anorexia nervosa, bulimia, and other similar eating disorders, it is possible that the purposes of primary prevention and early identification will be achieved.

Educational Background. The literature demonstrated that the populations suffering the highest incidence of such eating disorders as bulimia or anorexia were relatively well-educated. Specifically, that meant that one or both natural or step-parents had received formal education that included college or post-bachelor study.

The data regarding the formal education of the respondents shows that those who were most concerned about receiving more information about the problems were in the same well-educated population that suffers a disproportionately high rate of anorexia nervosa, bulimia, and related eating disorders. It was not clear whether the people who responded were participating in the survey because they had relatives or close friends who suffered from such disorders, or whether they were simply more aware of the problems of anorexia, for example, because they were, overall, more educated and aware than the general population surveyed.

Regardless of the motivation that spurred the respondents to either return or ignore the surveys, the outcome is nonetheless pertinent: that the men and women who responded to the survey fall into the same educational categories as the general population that seems to suffer a higher incidence of anorexia, bulimia, and related eating disorders.

It is possible that those who have been alerted to the epidemic proportions of potentially morbid eating disorders afflicting mem-

bers of their socio-economic group might be particularly responsive to surveys directed at asking the general population for specific questions, so that the goals of prevention and early identification can be achieved. This observation is made on understanding that people often respond more promptly and completely to issues that impact on their lives, or the lives of others, who they feel are like themselves, (Huff, 1953).

Occupational Status. The thread of shared characteristics between the sample population consisted of those who completed the surveys, and the population suffering the highest incidence of anorexia, bulimia and other similar eating disorders.

The literature has established that those families producing anorexic, bulimic or bulimarexic young people tend to be in the middle or upper socio-economic brackets. That social and economic standing is typically derived from parental involvement in professional work that yields relatively high income for the family. This professional level employment is often typical of the parents in the family system, and is equally typical of the aspirations of the children or young adults who are stricken with the eating disorders.

The literature search yielded data confirming that while middle and upper-middle class Jewish and Italian families tend to suffer most profoundly from those eating disorders that are the subject of this study. The survey yielded data demonstrating that the professional people are most numerous in the overall population seeking information about anorexia, bulimia, and related disorders.

It would be fallacious to assume that all members of the population comprised of professional employees or independent workers are equally interested in knowing more about eating disorders. However, the survey demonstrates that the people who occupy professional job slots express their interest cogently and in the manner solicited by the researcher.

It is possible that other survey instruments may have been more successful in eliciting information from younger people who were not yet in professional work, but who were basically seeking professional employment in their future. It is further possible that the format, which seemed to extract a greater response from older people, also appealed to people who were already employed in positions where making decisions, and formulating specific questions, was part of daily responsibility. Young people, particularly school-age youngsters who have not graduated high school, might have had difficulty responding to the format, which left so much responsibility to the respondent.

This was a necessary risk to run if the researcher was to elicit the questions that people really had, as opposed to asking people to agree or disagree about information, and then extrapolating what questions the people might have on the basis of that information. The approach that was chosen (see Appendix A) was more direct and personal, and allowed the respondent a maximum degree of freedom in determining responses to questions and categories.

While the degree of freedom seemed to have appealed to those who were already employed in professions of their choosing, the format might have seemed confusing to younger members of the tar-

get population selected for the overall sample. This reluctance was not evident in the pre-test of the instrument, when 3 high school age girls and 3 high school age boys were asked by the specific teacher to fill out the surveys and to critique the structure and nature of the survey instrument itself. The students reported complete satisfaction with the format, and noted that it was good that someone wanted to ask their opinions or their feelings.

The difference in the method of distribution to the pre-test sample and to the actual sample was that there was personal contact between an interested adult and the students, in the case of the pre-test. In the case of the actual survey, the students received the survey in gym class. This method was used in order to assure that male and female students were given equal exposure to the chance to take the survey, and to further assure that the male and female students were randomly chosen, rather than selected because they were in classes that were structured according to ability. Gym class is the single class that all students must take, and where there is no ability tracking.

The purpose of surveying this population in this fashion was to achieve equity in the distribution of the survey. However, the gym teachers did not make personal appeals to the young people the way the individual teacher appealed to the three youngsters in the pre-test sample. It is possible that the variable of personal contact between the high school age population and those distributing the survey was significant in determining the degree to which

the age group involved responded to the survey.

However, even if it could have been anticipated that a different distribution method might have resulted in a greater response from high school age or college age students, the distribution of professional people within the population of respondents would have remained the same. There would simply have been more numerous responses from younger people who had yet to choose or enter professions or employment in non-professional jobs.

Therefore, it is evident that the people who were sufficiently interested in the topic to complete and return the survey share the same occupational characteristics as the individuals and families struggling with the profound suffering related to eating disorders such as anorexia or bulimia.

Just as the literature demonstrated that there is a relationship between the socio-economic status of a family, and the likelihood of the family to produce at least one family member who is anorexic or bulimic, the survey that was conducted for the purposes of this study demonstrates that the religious groups of the respondents are essentially the same as the religious groups of the families of anorexics or bulimics.

Religion. The vast majority of those who responded to the survey were either Jewish or Catholic. In fact, fully 81% of the respondents fell into one or the other category.

According to the literature reviewed in Chapter II of this study, the Catholic population suffering the highest rate of anorexia and bulimia was Italian. However, there was no category

on the survey for the respondent to note his or her ethnic or national background, beyond the fundamental and general category of religion.

Given that there was no category for specific ethnicity outside of the parameters of religion, it is not possible to draw a highly specific relationship between the characteristics of the surveyed population and the characteristics of the typical treatment population. However, the respondents did share the same religious background as the typical treatment population, in that the majority of the respondents were either Jewish or Catholic.

Once again, those who were sufficiently interested in eating disorders to respond to the survey shared an essential and common characteristic with the treatment population.

Geographical Location. The purpose of eliciting general information regarding geographic location was to determine what steps would best be taken to reach target audiences, when the publication was prepared for distribution. Therefore, there will be no specific treatment or discussion of this data, in terms of its relevance to typical treatment population, or to the overall body of data gathered through the literature or the survey, except to note the following: the majority of the men and women who responded to the questionnaire came from urban and suburban neighborhoods in New York, New Jersey, and Connecticut, with a considerable portion of the respondents coming from Long Island.

It is demonstrated in the literature that families coming from

urban and suburban middle class and upper-middle class settings tend to produce more anorexics and bulimics than do other families. To that extent, the sample population of respondents does match the typical treatment population.

However, it is invalid to pursue that connection very far, since there is no specific information supplied regarding the exact nature of the communities from which the respondents came. Since the purpose of gathering data regarding the geographic location of the respondent was simply to determine the best avenues of distribution, there is no deficiency in relation to the instrument.

Overview of the Results and Discussion

There are several points that emerge from the results of the study, and the discussion of the specific categories of those results. First, there is the overarching point that the women and men who responded to the survey share many common socio-economic characteristics with the treatment population.

The respondents consistently fell into the same social, professional, and religious groups that typify the anorexogenic family, as well as the family of the bulimic. These families are predominantly white, middle class, and of Jewish and/or Italian descent. The family can be a combination of Jewish and other religious backgrounds, and can be a combination of Italian and other traditions. However, if the Italian or the Jewish heritage is dominant in the family system, there seems to be an increased likelihood that onset of bulimia or anorexia will be precipitated by

multivariate social, interpersonal, and psychological conditions.

"A family fostering the development of an anorexic is typically upper-middle class or middle class, and achievement oriented, possessing values to some extent reinforced by society. Exemplary performance is valued but without a sense of personal pride or pleasure. Thinness as an appealing physical appearance is over-emphasized by the parents," (Rumney, 1983:2-3).

It has been argued in the literature that anorexia nervosa and related eating disorders develop in the wake of events or series of events that disturb the homeostasis of the family, (Gross, 1982:10-11). This argument is part of the professional debate regarding the psychological reasons why an individual within a given family system might develop this particular set of somatic disturbances, evidence in food abuse and generally self-injurious behavior.

However, even the proponents of the psychological model cannot dismiss the interactive effect of the data regarding the social and economic factors that seem to be correlated with the onset of the eating disorders studied in this project. These social and economic factors include, but are not limited to: the sexual oppression of women; the perceived pressure that women tend to feel to look and behave in a certain way; the pressure from parents and from a variety of significant others to perform and achieve within the boundaries of the adult's expectations; the perceived pressure to become sexually mature and adept essentially at the onset of puberty.

Middle and upper-middle class America seems to place a premium on achievement and appearance without necessarily attaching intrinsic

sic importance to accomplishments that are lacking in prestige. Appearance can be more significant than substance, and the children of the families interpret this message as an ultimatum: they must look a certain way as they take what seems to be the right steps to achieving approved goals. This was established by M. Gross, in his book, Anorexia Nervosa, published by Collamore in 1982.

It is clear that the respondents repeatedly asked questions about social, psychological, cultural and economic pressures on families and individuals, and how those pressures might make certain groups or individuals more susceptible to the onset of anorexia, bulimia, and related eating disorders. The fact remains, however, that many of the questions posed by the respondents were interdependent, and many overlapped, because the categories were, by definition, inter-related.

For example, the category of social reasons could overlap with a category regarding sex role identification. Both of those categories could, in turn, be considered part of the psychological development of individuals suffering anorexia and bulimia. The range of their questions reflected the fact that they were looking for more information than has already been presented in the popular media.

The results of this study became the foundation for a guide that is both readable and informative. It can be used by teenagers, preteens, and adults to find out more information regarding the most popular questions asked about anorexia and bulimia, as those questions emerged from this survey. This guide is titled

Everything You Always Wanted to Know About Anorexia and Bulimia, But Were Afraid to Ask, by Marc Zimmer, Ph.D.. Naturally, the guide does not pretend to answer all the questions that exist regarding anorexia nervosa, bulimia, or bulimarexia. It was designed to answer certain basic questions, to the extent that the literature suggests answers to those questions. It is possible that there are more complete answers necessary for certain families or individuals, and Dr. Zimmer urges all readers to seek further personal help for answers to questions that are not included in the guide.

NARROW ESCAPE

There you stood,
skeletal and defiant,
A silent scream
unleashed by my
unexpected appearance
Speechless, I allowed you to pass,
naked and unashamed,
Your taut, translucent skin
shot scarlet and pale blue
beneath
The unforgiving flourescent.
As I watched, you stepped beyond
my narrow sphere of sight -
beyond my untimely reach -
And vanished
before my eyes.

R.A.B.

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CHAPTER IV

TRANSLATED PRODUCT FOR THE LAY PUBLIC

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT ANOREXIA
AND BULIMIA, BUT WERE AFRAID TO ASK

Preface

When an individual or a family suffers a profound loss or disturbance, the homeostasis of the family or individual is often violated. The result is a state of disequilibrium that can confound treatment through a multiplicity of symptoms that mask the nature and depth of the actual disturbance.

The same set of conditions and outcomes applies to those periods in history when society suffers loss or disturbance. The interactive effect of social disorder and familial or individual trouble can contribute to the onset of psychological dysfunction. Anorexia nervosa, bulimia, and the newly identified related variations, such as bulimarexia, seem to develop as a result of the interaction between personal, family, and social factors that are discussed in depth throughout this guide.

This author suggests that societies, like families, suffer disturbed homeostasis when the society sustains profound disturbance. American society has withstood a series of social, economic, and cultural shocks throughout the twentieth century, the scope of which elude adequate or even cursory treatment in this preface. However, there are specific social conditions,

or factors, that seem to be significantly related to the entrenchment of such disorders as anorexia or bulimia within specific sub-populations of the American people.

The first such social condition is the enormous pressure placed on the female population to achieve and maintain a physical appearance that is matched in its perfection and desirability by virtually no other type of achievement. The majority of women surveyed in the United States would prefer to lose 10 pounds than get a promotion with a considerable increase in salary. Clearly, women have been conditioned to attach more significance to their physical appearance than to their professional development, or recognition of that development.

Women from middle and upper-middle class families receive the same multi-media, social, and cultural message that sexual development is the equivalent of success, and that sexual development hinges on desirability, with desirability, in turn, hinging on physical appearance. The sexual development carries with it inestimable and often premature burdens to become competent and independent at an early age. Young women in this social and economic bracket often report that they feel enormous pressure to perform academically, socially, sexually, and professionally, according to the terms defined by their parents and their selected peers. They have very little sense of their own ability to define or achieve personally-set goals. They rely on the social system and the family to define those roles.

This new set of modern pressures, particularly on young women,

frequently causes the young women to feel that they simply cannot be what their parents or the social structure expects them to be. Body image becomes increasingly and profoundly distorted, and the victims focus their considerable energy and productivity at achieving within the only set of boundaries still under their personal control. Those boundaries are, very simply, the physical limits of the human body.

Those suffering from anorexia dominate their bodies with a grim satisfaction that they have achieved their goal, no matter what the cost, and they have thus succeeded according to the new social rules of the 1950's, 60's, 70's, and 80's in America.

The problem, clearly, is that they have literally and unconditionally accepted the letter and the message of the society and the family. These victims do not have the resilience or the self-esteem to challenge the family or social mandates regarding achievement and perfection, and they are often doomed to die as they embrace the precise, if distorted, social and familial Command to achieve.

Even if societies, socio-economic sub-groups, or ethnic groups suffer transient or permanent disturbance in homeostasis, it is nevertheless the obligation of the professional mental health community to help the individual members of the society to overcome, identify, and/or prevent specific problems from developing as a result of the destabilized social homeostasis.

This guide has been prepared in order to meet that essential goal: to equip the individual or small group to identify, prevent, and fight such somatic symptoms as anorexia and bulimia,

which develop as a result of the disturbed homeostasis of the family, ethnic group, or society at large. The guide is structured so that the reader can progress from topic to topic, or scan various topics, in search of the single most pressing question that she or he might have regarding the nature or treatment of any of the eating disorders covered in this study.

INTRODUCTION

You hear it all the time. From television, radio, and magazines, and maybe from your family and your friends. It's smarter to be thin than not thin. Women who are thin have a better chance of marrying nice, successful men. Girls who are thin get more dates than the other girls.

If you want to be successful at work or in the social world, it is supposed to be better if you are thin.

The problem is particularly troublesome for women. Women and girls simply have more body fat than men. The body fat is part of the woman's biological make-up. It's part of what makes her physically capable of developing and ultimately becoming a mother.

Even if you are a girl or a woman, and you do not want to become a mother, your body develops according to a biological plan that has nothing to do with what your personal plans might be about marriage, or parenthood. So women and girls have a greater struggle in the battle against weight gain than do men and boys.

And it really is a battle. In fact, there is a war going on, and some people are dying. When they aren't dying, they are

getting very sick. Right in the middle of families and neighborhoods where the refrigerators are filled all the time, and there is always enough money to buy more food, there are thousands of girls and women who are starving. There are some boys and men, as well.

Starving is not the only way some people cope with the pressure to be thin. Some people give in to the physical and psychological urge to eat, and then they eat until they are sick. They eat enormous amounts of sweets or other foods, and then they feel angry, depressed, and sick. So they purge their bodies of all that food. They use pills and they make themselves vomit, but they make sure that they lose the food that they have just eaten.

What are these people suffering from? The first group of people, who are starving in the midst of plenty, are called anorexics. They are suffering from anorexia nervosa.

The second group of people are suffering from what is called bulimia, and they are called bulimics.

Then, there are those people who suffer from both disorders. When a person starves herself, and also engages in bingeing and purging, then the term that is used is bulimarexic. That means that the individual suffers from the combined symptoms of both serious disorders.

This guide have been prepared to help answer the questions that high school students, college students, parents, teachers, and others have asked about anorexia, bulimia, and bulimarexia. The first section of this guide has been developed to help you

understand some of the basic terms that have been used throughout this guide.

If you understand the basic terminology, then you have taken the first step toward understanding a problem that is literally robbing America of the lives of thousands of its young people.

You can become part of the solution, even if the only step you take is to encourage the people you know and care about to do what they want to do, and to feel confident that you will care about them, no matter what they weigh or how much they achieve at work, in sports, or in social settings.

PART I

BASIC TERMS

ANOREXIA NERVOSA

Anorexia nervosa is a disease that affects more girls than boys. In fact, girls and women suffer more than boys or men, at a ratio of 9 to 1.

People suffering from anorexia nervosa are called anorexics, and they are deeply involved in their body image. They think they are fat, even if they weigh 25 pounds less than they should, according to their height. So a young woman who is 5'4" may think she is fat, even if she weighs 80 pounds.

Anorexics usually become sick when they start to diet. They often start to diet because they have been told by someone else that they admire or love, that they should lose weight. However, they also can start to diet fiercely on their own, when they see

that they are developing new physical traits that are usually associated with puberty.

Anorexics often exercise at a continuous rate, to the point that they will stand up and type, or they will jog in place while they wash dishes. They are deeply fearful that they will retain fat from lack of exercise.

Bulimia

A bulimic person is harder to identify than an anorexic, because bulimia does not necessarily cause a person to suffer severe weight loss. In fact, bulimics often appear to be within normal body weight, within a range of 10 pounds more or less.

Bulimics control their weight through two basic steps: they purge with pills or other medication; they make themselves vomit. These two steps make it possible, from the point of view of the bulimic, to binge on any kind of food they want.

Bulimics do binge, or eat uncontrollably, and they often do this out of anyone else's sight. They will often eat foods that are easy to transport, to hide, and to swallow, like junk food, such as ice cream or cake. They literally eat until it hurts. The only reasons they will stop is if they are interrupted by someone, or if they experience severe abdominal pain.

Then they vomit, or they take medication that will loosen their bowels, so that they will not retain any of the calories that they have just taken in by bingeing.

How many people does this really effect? Up to 1 out of 5 college women, and perhaps a similar ratio in high school and

junior high school. And then there is a whole other group of people, who have symptoms that are somewhat different than the ones you have learned so far. Read on!

Bulimarexia

Bulimarexia? That's right. It is a disorder that means exactly what it seems to mean. It is a combination of bulimia and anorexia. People who suffer from bulimarexia present the severe weight loss of the anorexic, but they also binge and purge, like to bulimic.

The classical anorexic either starves herself, or diets so strenuously that she ultimately eliminates most foods from her list of what is good to eat. The bulimarexic is not as militant about not eating.

Basically, the bulimarexic will diet, starve, and purge to meet her weight loss goals. But she will also binge, which makes her different from the anorexic. Her tendency to starve herself, and drop up to 25 pounds or more below body weight, makes her distinctly different from those who suffer from bulimia.

Given these differences, it was necessary for the professional community to come up with a name for the syndrome that increasing numbers of patients seemed to present: bulimarexia.

More Specific Questions

The rest of this guide will give you answers to the questions that are most frequently asked about bulimia, anorexia, and bulimarexia.

The guide has been divided into separate parts, so that you

can refer to the parts that interest you the most. Or you can just read through, and find questions raised that you may not have thought of on your own.

This guide has been constructed to answer the questions that students, parents, teachers, and other concerned people have raised. Hundreds of people were surveyed to find out just what the most common questions might be regarding why people suffer from eating disorders, what the eating disorders are like, and how these disorders can be treated.

We hope that you will find the answers to your own questions in the following pages. Each part begins with a quote from someone suffering from anorexia, bulimia, or bulimarexia, or from someone who cares very deeply for someone with such an eating disorder. You will be able to read directly just what these individuals and families endured in their struggle against these potentially fatal problems.

Just one more word, before you begin. These eating disorders are symptoms. They develop when people suffer deep depression, anxiety, and anger, in families and societies where attitudes toward weight and food are intense and contradictory.

Sometimes, we have a very hard time accepting self-destructive behavior in others, particularly when people we care about are involved. We sometimes refuse to accept that someone we care about deeply could develop a psychological disorder that can cause them irreparable physical harm.

Then, there are times when it is hard to take steps to bring someone we care about to the attention of someone who can help.

If we take that kind of step, then it means that we have recognized that there is a problem. Recognizing and admitting that a problem exists can be as hard for the friend or relative as it is for someone who is suffering from the problem.

Consider this point, though. If you are suffering from one of the eating disorders covered in this book, then you probably deny the problem. That means that you will probably not seek help on your own very quickly, until you experience a serious scare that makes you realize how badly you are hurting yourself.

If you are the friend or relative of someone who you think might be anorexic, bulimic, or bulimarexic, then you have a similar unwillingness to admit the problem, in many cases. But if you admit the problem, you may make it less difficult for the person you care about to admit that problem, as well.

For example, maybe your friend or room-mate in school is throwing up constantly. You might ask yourself if she is having morning sickness, or if she is purging. If you notice this problem over time, what do you do? You will get answers to these and other common questions right here in this guide. And as you absorb this new information, you will be able to read comments and quotes from people who have suffered from these disorders, as well as from people who have lived with and loved women and girls who have struggled with the life-threatening disorders of anorexia, bulimia, and bulimarexia.

The names of the people you will be reading about have naturally been changed to protect their privacy. But they are people who are just like the rest of us -- trying to fit into the world,

do the right thing, and take care of each other.

PART II

PHYSICAL SYMPTOMS AND PROBLEMS

Section I: Anorexia

Maria L.: A Post Mortem

It is said that war reverses the natural order of things, and forces the parents to bury the child. If that is true, then social and family pressures can extract the same price as war. Mrs. L., Maria's mother, reports on the short life and lingering death of her only daughter.

"Maria was always a beautiful child. Lovely, bright, and very capable. Whatever she did, it was perfect. And she could cook! When she was only nine, she was such a help in the kitchen. Her father was so proud -- he would say her sauce was even better than mine!

"Everything was fine until she was about 11 years old. She had put on a little weight, and I warned her, in this family, the women put on weight fast! When the period starts, so does the sentence, that's what I told her. Kidding around, but I was just interested in her health, and that she should stay beautiful. I work hard on my figure, and she knew that.

"My own mother told me the same things, and I never got the idea I should starve myself! God in heaven, I never meant her harm! I didn't even notice at first. She was on a diet, just like me -- and all the women and girls in the neighborhood. We

all had foods we could eat, foods we couldn't. But her lists were always different. Maria, she had to be the best.

"All of a sudden, she was so skinny. I talked to the girls at work, and they kidded me. They said maybe I was jealous because she could take off so much weight, but this was crazy. We thought, well, it was a phase. You know, kids do crazy things, and they grow up anyway. And a fat girl has it so tough.

"Finally, she was so thin -- you could see right through her skin! Her period stopped, you know, so we took her to the doctor, but he just gave her hormones, to start the period back up.

"We didn't get to a good therapist until our little girl was so skinny you could see right through her skin! We didn't mean to wait. It just crept up on all of us. Suddenly, I saw her naked getting out of the shower, and I couldn't help it. I cried like I saw a corpse. She was like a picture from some foreign country, like she was starving to death. My own little girl."

Maria L. did literally starve herself to death. The entire process took almost 8 years. In a sea of plenty, Maria had died for lack of food. And she was ill for a very long time before anybody ever recognized that something was wrong. In fact, from the time that she developed symptoms of anorexia, to the time that her mother and father got frightened and took her to the doctor, a full 18 months had passed.

It took Maria's mother and father a long time to recognize that their daughter was not going through a simple teen-age phase. Maria's friends were too busy competing with her, and admiring her willpower, to notice that Maria was disappearing before their

eyes.

You can imagine that the guilt that her parents and her friends suffered was intense, to say the least. And in addition to guilt, those same parents and friends felt anger. They were angry at their daughter, and they were angry at themselves.

They were angry at their daughter for taking the quality, and ultimately the very breath, of her own life. But, more than anything else, they were angry at themselves for having failed to take the best steps they could to help prevent or identify the development of anorexia in the early stages.

They had absolutely no idea what the physical signs of anorexia were. They had heard about it on television, and they had watched a program about celebrities who suffered from this disease, but their daughter was no celebrity. Do you believe that they really wanted their daughter to suffer or die? Nothing could be further from the truth. They adored Maria. They simply had no idea that such a condition as anorexia existed, or that anything could be seriously wrong with someone who was clearly doing everything right, so far as they were concerned.

What physical changes took place in Maria? What physical changes usually take place in people who are developing anorexia?

You can probably mention some of those physical changes right now. Very rapid and noticeable weight loss is the first, most obvious sign of the actual onset of anorexia. You might say that there are plenty of people who lose a great deal of weight, and who are not anorexic. That is true. But those people are usually very happy with their new, slimmer appearance. They eat normally,

and make sure that their diet is balanced, even when they have restricted their caloric intake.

When someone you care about is dieting with military diligence, and when they make long lists about good and bad foods, and when they never seem to have lost enough weight, you are seeing warning signs, just like the flashing lights at a railroad cross. DANGER. Ignoring these signs can lead to injury and even death!

Anorexics frequently reduce to fully 25% less than their suggested normal body weight. They still feel fat, even then.

Girls and women who suffer from anorexia frequently stop having their menstrual cycle. The menstrual cycle is a hormonal process, and the mature female sustains that hormonal process in part by maintaining at least 18% - 20% body fat. When a woman or adolescent drops her body fat below that level, she can experience an interruption of the menstrual cycle.

Very often, a physical warning sign can be the weight of a young person before the weight loss began. Young people who become anorexic have often been overweight during childhood.

Puberty can be a very delicate time. A young woman can suddenly gain weight, or experience a redistribution of body fat that makes her shape openly and completely different. Careless comments from family, teachers, or friends can make the young person so self-conscious that she will diligently diet away the offending fat. So another physical sign can be rejection of the basic changes that take place as part of puberty.

Basically, the anorexic young person decides to make her or

his body fit the mold of the perfect pre-adolescent. The result of this self-destructive campaign to lose weight is that the person becomes as emaciated as a starving child in a picture from a nation suffering from famine.

Since the anorexic person is not eating normally, nutrition becomes a critical issue. Anorexics tend to get sick more often than most people, because their resistance is lowered by their poor nutrition.

What are some of the physical changes that you can ask a doctor to look for if you go with your anorexic friend or family member on a visit to the physician? If you go with your friend or relative to the doctor because you are worried about an extreme level of weight loss, you can help your doctor find out if that patient is anorexic by reminding her or him to check the following physical signs, described below.

Blood Pressure

Is the patient's blood pressure lower than normal? Relatively low blood pressure can be a sign of anorexia, when it appears in people who have lost a great deal of weight very suddenly, and who have continued to drop their weight below normal for their height.

Body Temperature

Is the patient's body temperature lower than normal? Hypothermia, which means the reduced body temperature that leads to freezing under certain conditions, can develop in anorexics.

Pulse Rate

Anorexic's frequently experience a low pulse rate.

Swelling

Edema, which refers to swelling in the body, is also a symptom of anorexia, when the patient presents a variety of the problems listed in this section. Ankles and legs may swell up, in particular, and the doctor ought to check for this symptom.

Hair

Body hair, facial hair, and hair on the head can change when someone becomes anorexic. That means that hair on the head can fall out; it also means that body and facial hair can change.

Other Physical Signs

These physical signs can only be checked by a doctor. They include the possibility of a damaged liver, abnormal protein count (from not eating properly) and/or a low white blood cell count.

All of these symptoms may sound ugly or upsetting, but they do develop when people stop eating and begin a campaign to starve themselves. **Remember:** your friend or relative does not have to show all of these signs before you encourage her or him to go to the doctor.

This description of categories is just a check list that you can use to see if the person you care about is really suffering from the disease you are beginning to understand as **anorexia**.

Section II: Bulimia

Are there different physical symptoms for bulimia?

Yes. The physical signs of bulimia are very different. First of all, the bulimic may never drop very far below normal body weight.

In fact, the bulimic may go through a constant, moderate shift in weight, from being a little below normal body weight, to being a little above normal.

Bulimics do eat. However, since they binge and purge, they go through their own special set of physical problems. For example, many bulimics suffer from dizziness, headaches, and a related blood sugar problem called hypoglycemia.

The hypoglycemia, which is basically defined as a lack of sugar in the blood, develops because the bulimic usually eats food with a great deal of sugar. When a person eats a great deal of sugar, the body responds by demanding more and more, through a complex process involving the body's release of insulin.

A doctor has to conduct a test to see if a person is suffering from hypoglycemia, and many people who are not bulimic do suffer from this blood sugar disorder. However, if your friend or relative is chronically tired, irritable, and seems to crave lots of sweets and starchy food, he or she may be bulimic.

One more point. Hair is a fairly sensitive indicator of health in many cases. In the case of the bulimic, hair on the head may fall out or become very dull, as a result of the poor nutritional state brought on by bingeing and by not allowing food to be properly metabolized.

PART III

PSYCHOLOGICAL ASPECTS OF ANOREXIA AND BULIMIA

SECTION I: Bulimia

Jennifer T.: From Cheerleader to Just Staying Alive

"I wasn't really hung up on weight or food or anything when I was in junior high school. I started to binge and purge later on, in high school. It was like I kept on trying to please everyone but me, and I was deathly afraid that I would get fat and then no one would like me at all.

"When I got into high school I found out that my best friend had purged a lot just before she got picked for cheering. She lost about 15 pounds in 10 days! So I tried it, and I lost weight really quickly. My boyfriend said I looked perfect, and my mother said the same thing. So I kept on trying to look perfect and be perfect.... I really drove myself crazy.

"Growing up in my house, it was hard not to eat, believe me. My mother is a great cook, but she basically cooks for my dad and my brothers. She always warns me not to eat too much. And so does my father. He says no guy wants to take a girl out who's always stuffing her face, and I guess he's right a lot of the time.

"So I figured out I could have my cake and eat it, too! I would eat in secret, because I was always hungry, and then I would just take lots of over-the-counter medicine, like laxatives to purge all the food. And I would make myself throw up.

"Everyone kept saying I looked so perfect, it was great! But I always felt sort of sick. I had a friend who did TV commercials, and she did the same thing, and we just decided that this was the way to do it. To stay pretty and popular, and to look like the models look. My father would always say that I looked like a model."

Jennifer left home for college this past year. She reports that she stopped her bulimic behavior after she went through intensive individual and family therapy. She has followed through on plans to join a self-help group on her college campus, to help make sure that she continues to eat normally and feel good about her physical self.

When Jennifer first came into therapy, she was suffering constantly from nausea and dizziness, and she was angry. Even though everyone said she was perfect, she did not feel perfect! So she decided she was crazy. Her question is one of the most frequently asked of all questions about bulimia:

What psychological problems cause a person to become bulimic?

Although each person is unique, there are certain basic psychological problems that many bulimics share. These are listed below:

An extreme fear of fat

Bulimics are very fearful that they will become fat, but they also want to eat. So they suffer from intense feelings of guilt over their desire to eat, since eating is definitely in conflict with their fear of becoming fat.

A strong need for approval

Bulimics report that they desperately wanted to please the people in their lives who they loved and/or needed the most. They wanted parent approval, approval of boyfriends, and approval from girlfriends, as well.

Depression

Sometimes, people who are depressed about themselves become

bulimic so that they will make themselves happy and make the people who they love or admire happy. However, depression can also develop as a result of engaging in bulimic behavior. Bulimics do their bingeing and purging in secret. The act of hiding what they see is disgusting behavior, and the inability to change that behavior, can contribute to making the bulimic feel deeply depressed.

The depression can cause the bulimic to become angry at herself, and can even prompt the bulimic to feel suicidal.

An added point about psychological problems.

Not one of us can say that we escape the pressure that comes from the media, or from the social value system as a whole.

Television, radio, and magazines place an enormous amount of pressure on us to perform and to look a certain way. Girls and women, in particular, constantly receive messages that tell them to stay skinny, but to feed everyone else very well.

Those media messages tell us that if women and girls stay thin, they will be desired by men, and they will be more successful at work. In fact, there are commercials that show husbands leaving home and going next door for better food!

But during all this feeding and nurturing, girls and women are supposed to stay thin. These conflicting messages are found in the media, and in the family system.

If the family system and the individual maintain the same basic values promoted by the media, then many young women develop bulimia to cope with the conflicting demands involved in staying thin and still feeding everyone else. Therefore, it is hard to

separate the effect of the media from the overall psychological problems experienced by the young women, and sometimes the young men, who suffer from bulimia. Basically, the pressure from the media is part of the psychological conflict and pain that the bulimic endures.

Section II: Anorexia

Is anorexia caused by the same psychological problems that cause bulimia?

Yes and no. The psychological effect of the media and cultural pressure is essentially the same; the anorexic receives the message thin is better, and thinnest is best.

The anorexic has a different set of problems in relation to body fat, and growing up. Anorexia involves extreme weight loss, with the victim striving to become thinner and thinner, no matter how much weight has been lost.

The anorexic uses the act of personal starvation in order to achieve certain very specific goals and objectives. For example, the anorexic can choose personal starvation as a means to taking some control over her, or his, small world. If the rest of the world seems to be controlled by parents, teachers, and other powerful people, then the anorexic can be assured that her or his body is the only sphere where her or his decision to eat is final.

Sexuality terrifies the anorexic as much as food intake. Girls and women who are anorexic tend to reject their sexual de-

velopment, and they act on this rejection very specifically. They starve themselves to the point that they look more like girls who have not yet reached puberty. This means that there are anorexic women who are 18 years of age who look like they are 10 years old, and desperately ill at that.

So we have established that fears of sexual development and growing up are part of the background for most anorexics, as are fears of becoming fat. Anorexics are also perfectionists, and when they are given directions regarding something that they must accomplish, then they often take that direction without debate. When a young woman who is dependent upon her parents, confused about her capability to function as an independent person, and fearful of developing sexually, receives messages from home and other places that she would be better if she were thinner, then she may devote her whole self to the process of becoming thinner.

The psychological picture of the anorexic is incomplete without pointing out that the majority of victims are fiercely competitive. They will set a goal, and they will attach that goal with all of the fervor of a zealot. If they are in sports, for example, they will definitely go for the gold. There is no play for the sake of play, and no generous losing.

The anorexic also suffers from a seriously distorted body image. Basically, the anorexic sees herself as fat, no matter how thin she or he is. This is not just an issue of visual perception, where the victim might look in the mirror and see herself as fat when she actually weights 85 pounds. The issue reaches beyond that level, to the psychological perception of where the

body ends and the rest of the world begins. This might be a difficult concept to absorb, so it has been broken down into the most manageable pieces possible.

When children are in infancy and early childhood, they learn how to make their bodies move in certain directions to accomplish certain tasks. They also learn the limits of their bodies, as well as the warning signs that a body can give. Such warning signs are connected with urinating, defecating, sleeping, seeking physical affection, and eating when hungry. People who develop anorexia have very poorly developed abilities to read the physical warnings of their own bodies. There are a variety of reasons for this problem, and those reasons are discussed more fully in the section regarding family. For now, it is important to establish that the anorexic does not have confidence in her, or his, ability to make judgements as simple as sensing hunger or estimating potential danger.

In addition to the above set of psychological disturbances, it is necessary to understand that depression is a key characteristic of anorexia. There is still debate at present over whether the depression is a result or a cause of the anorexia. However, it has been firmly established that anorexics do suffer from depression.

Some of the depression that anorexics suffer may be linked to a feeling of grief that they have not confronted or resolved, the way people must face and recover from grief in order to keep on growing and adjusting to life. That grief could be over a traumatic experience, such as the death of a parent or other loved

one. Or it could be grief over the fact that warm, loving, and stable relationships were never part of family life, from infancy on through to adolescence.

In this section, we have been able to construct a psychological picture of the anorexic, with that picture consisting of the following basic parts:

- | | |
|---------------------|---|
| ___ DEPRESSION | ___ DISTORTED BODY IMAGE |
| ___ ANXIETY | ___ CONFUSION OVER PHYSICAL
LIMITS AND NEEDS |
| ___ COMPETITIVENESS | ___ PERFECTIONIST |
| ___ ANGER | |
| ___ GRIEF | |

However, this psychological picture is incomplete. In order to complete the whole portrait, it is necessary to cover the role that the family plays in the onset of anorexia, bulimia, and other similar eating disorders. In the following section, the most commonly asked questions will be answered, regarding the relationship of family to the anorexic, and vice versa.

PART IV

THE ROLE OF THE FAMILY

SECTION I: ANOREXIA

When Home is Where the Heartache Is

"I still have a hard time accepting it. The therapist says that all of us have contributed to Rachel's eating problem. Anorexia, that's the problem. And I have since learned that our family is called an anorexogenic family.

"It makes me bitter, really, because I always thought we were the perfect family. We were always so close. And we always accomplished the goals we set. That's what a family is supposed to do -- give each other the strength to get things done!

"I cannot describe how frightened I was when I realized that my daughter was so thin she could have been one of those kids you see in the paper, who you can adopt through the mail, for something like a dollar a day? She looked like that. And we live in Westchester.

"All my life I worked to make sure that my wife and daughters would be safe and secure. That we could offer the kids everything. I know we always demanded a lot from her, but we gave a lot, too, you know. You don't get something for nothing in this world.

"Then suddenly, you end up in therapy, and you have a counselor telling you that all the things you figured were basically pretty normal or average aren't normal at all. Even if they are average. It's like we've had to re-think our whole family, and build from the foundation up. Like a terrible fire destroyed everything.

"I only hope my little girl will be okay someday."

The father whose story you just read was in the process of participating in intensive family therapy because his 12 year old daughter was suffering from late-stage anorexia. She was still entrenched in the anorexic behavior, and was receiving treatment in a hospital setting at the time of this interview.

One of his first questions, echoed by his wife, is also

one of the most frequently asked questions in the general public. It is: What are the typical family characteristics that contribute to the onset of anorexia in one or more family members?

Before listing these major characteristics, it is crucial to understand that not all anorexics emerge from family's that are described in this section. Just because a family does not exhibit these characteristics does not mean that a child cannot suffer anorexia at some point, or that a young adult, male or female, will always have a healthy attitude toward food intake.

The characteristics, described below, are typical of many families where a family member has developed anorexia, or seems to be moving in that direction. You can use that information to help understand certain family problems that can contribute to the onset of anorexia. However, it is important that you be alert to the possibility that a family can produce an anorexic individual without having the characteristics that are typical of families of anorexics.

Talking about family-related problems that might contribute to the illness of a family member is always difficult. There is a temptation to look for blame when people talk about family problems, and it is easy to fall into the trap of taking sides as if the disease were an argument.

Eating disorders develop because the whole family is suffering. It is an anorexic who shows the desperate, dramatic signs of the family dysfunction, but it is evident from the research that anorexia develops within the context of the family system. Therapy does not direct energy at assigning blame. Instead, therapy directs energy toward healing and understanding, through restructuring the family system. As you can tell from the father's quotation in the beginning of this section, the process of restructuring a family system is painful for a while. But the re-

sults can be very rewarding, after a family recognizes how and where it has contributed unwittingly, in most cases, to the destruction of one or more of the family members.

With this background, you are now ready to absorb the information regarding the role of the family in the majority of cases where an individual family member develops anorexia.

1) The family that produces an anorexic is frequently referred to as the **anorexogenic family**. That means that the family as a whole contributes to the onset of anorexia in one or more family members.

2) Anorexogenic families tend to be tightly **enmeshed**. That means that independence from the family system is discouraged; dependence upon the family members in general, and the parents in particular, is encouraged.

3) When a family is deeply enmeshed, it is difficult for a child to separate from the family, or to initiate any important action. That means that the child can grow up depending upon parents to set limits, define what is good, explain what is bad, and decide how to do almost everything the way that the parents feel is the best. The child does not develop the capacity to make independent judgements, since she is not encouraged to take risks, or experiment with outcomes.

4) It is likely that the most important thing in the life of the parents in an anorexogenic family is the child(ren). Parents in such family systems tend to be extremely concerned about the child's safety and welfare at all times. This is a natural parental impulse, of course. However, parents in an anorexogenic family system crowd their children to the point where

the children are discouraged from taking any risks that might involve a measure of danger.

All teachers understand that learning and independence come from taking risks as well as from taking direction. A healthy balance is what enables a child to grow up and mature. If the child is unable to take risks, learning and growing up become difficult.

5) Members of the anorexogenic family system tend to complain fairly frequently about **somatic problems**. Somatic problems or issues are expressed physically. For example, if a person is very nervous, an upset stomach might be a somatic complaint, but the real problem would still be in the nervousness.

6) Anorexogenic families also focus a great deal of energy on the preparation, arrangement, discussion, and consumption of food. This does not necessarily mean that the people in the family are continually dieting. The point is that food and related topics, such as eating, are very important parts of the family members' communication with each other. There is much talk about food-related problems, such as the eating behavior of relatives, or the weight gain or loss of friends.

7) The family's intense concern about food and related topics combines with the family's unwillingness to let the child grow up and grow away from the family.

8) When a child develops symptoms of anorexia, the family can respond the same way that families of alcoholics respond. They become more deeply involved in the life of the victim, and they unite to protect the victim against the effects of out-

side concern or interest.

9) Developing symptoms of anorexia are first hidden by the family, since the anorexogenic family is best satisfied when family needs are met by family members. Outsiders are decidedly unwelcome if they intend to become important to one or more members of the family on a personal level.

10) A teenager or pre-teenager has a hard time establishing close friendships outside the family if the family discourages those friendships. The anorexogenic family tries to take over all of the important roles that children or adults need filled in order to have complete lives. The family basically tries to be all things for each other, so that no new people are introduced to the tight family system.

11) This tight family system makes early identification and care for the anorexic child very difficult. The family will typically reject the concern of outsiders, such as friends of the child, friends of the adults in the family, or other concerned parties, such as teenagers. Family inter-reliance is the name of the game for all family members, and the rule is to depend on each other. No one is allowed to break away, or depend on anyone outside.

As you can imagine, providing family therapy for such a family would be very difficult. However, there have been successful efforts to treat both individual anorexics, and the anorexogenic family members. This topic is covered more thoroughly in the section on treatment.

Section II

BULIMIA

Just as there are family system characteristics that contribute to the onset of anorexia, there are family system dynamics that contribute to the development of bulimia.

The bulimic comes from an entirely different family background, however. The individual who is bulimic, and who does not drop to a very low weight like the anorexic does, endures different pressures from within the family system. These special types of issues are described below.

1) The major difference between the bulimic's family and the family of the anorexic is that the bulimic has a far-reaching social network. S/he can have numerous friends and alliances, and can typically progress through adolescence without the fear of separation that takes place in the anorexogenic family.

2) Parents are very controlling in the family that produces a bulimic child. They are not as controlling as those parents who produce an anorexic, but they are more controlling than the parents of the general population of young people.

3) The controlling parents in these family systems tend to press the young people to achieve within the boundaries of what is socially acceptable. Marriage, financial achievement, social status, and appearance are all prized accomplishments, rewarded in the family; failure to achieve those conventional goals is punished by constant disapproval and family conflict.

4) Families of bulimics tend to suffer from a considerable degree of what can be called unexpressed tension or anger. The

family will usually avoid discussing the issues that really cause the tension and will choose to focus on the ability of a child to achieve certain socially accepted norms, such as weight management and good grades. That means that when the parents in the family of the bulimic are having marital problems, it is likely that both parents will focus their considerable energy on pressuring the daughter to achieve, because it is more agreeable for them to express their tension indirectly, projecting it onto their daughter, than it is for them to face themselves, and work out their problems. They may feel that their problems are too big to solve, and that they will direct their energy at making sure their daughter has the perfect life that has somehow eluded them.

5) Mothers in the bulimic family system often experience problems related to behavior management. That would mean that the mother might have to struggle against her own impulses to overeat, or to drink, or to engage in other physical excesses. The fathers, on the other hand, are frequently very close with their daughters while their daughters are young, but separate as the daughters develop sexually. While the fathers in anorexogenic families are deeply involved with the details of their daughters lives, the fathers of the bulimics tend to be remote.

6) Mothers and fathers of bulimics tend to encourage the children in the family to compete with each other, rather fiercely. This is another difference between the anorexogenic family and the family that produces the bulimic. In families that produce bulimics, there is often constant comparison of siblings, with

pressure on both sons and daughters to fight each other, and for each to try to win.

The above description covers the basic nature of the family of the bulimic. There is one more set of family characteristics that requires attention to this section. That is the set of characteristics that typically produces a bulimarexic child or adult.

Section III

BULIMAREXIA: FAMILY TIES?

The role of the family is just as important for the bulimarexic as it is for the bulimic and the anorexic. The following basic list describes the characteristics of the bulimarexic family system.

1) First of all, the bulimarexic family is focused on food and discipline, just as the families of anorexics and bulimics. There are all sorts of family pressures regarding the frequency, content, timing, and importance of eating, and there are usually two different standards for the men and for the women in the family. Typically, the women and girls in the family are expected to maintain a certain slimness, while the boys and men are not expected to keep that same type of appearance.

2) Mothers of bulimarexics tend to have more serious weight control problems than the other two populations of mothers discussed in this section. There is a higher incidence of maternal obesity, and maternal substance abuse.

3) Fathers of bulimics have a higher rate of substance abuse in their personal histories, with that abuse involving al-

cohol and other depressants or barbiturates.

4) Bulimarexics, like anorexics, are typically good children defined by the fact that they take great pains to achieve approval from parents and other important adults in their lives.

5) Like the bulimics and the anorexics, bulimarexics tend to come from middle or upper-middle class families where there is considerable emphasis placed on appearances and conventional achievement. However, in the case of the anorexic family system, the individual family members do typically achieve the goals that they set. In the bulimarexic family, the parents may often demand more of the children than they expect or achieve themselves.

6) As was the case in the previous two sections of this part of your guide, the family system of the bulimarexic tends to be characterized by conflict between the fathers and the daughters, and conflict between the mothers and the daughters. This is not to say that there are no young men who develop the disorder; however, the vast majority of bulimarexics are women.

Bulimarexics differ from their anorexic peers in that they do not fear food; they crave and seek out food. They do fear it, but they tend to obsess about fat primarily during periods where life becomes very stressful. When they feel that their behavior is under control in most areas of their lives, they are perfectly able to consume and retain normally balanced meals. They do diet like mad, however, and they control their continuous weight by bingeing, purging, and eating normally when they feel things have stabilized for them.

The bulimarexic does suffer the same sense of helplessness

that develops over time in the family system, and in the peer group, when it comes to facing their eating disorder. They will deny their behavior, and cover their tracks, so effectively and efficiently that it is possible to live in the same family as a bulimarexic and not know that there is any food abuse problem taking place.

Part V

ENVIRONMENTAL FACTORS

This short part has been added because many people responding to a massive study asked about environmental influences. However, when their questions about environment were studied, there were really two very specific categories of environment that the general population was asking about. These were:

- 1) **The family or home environment**
- 2) **The social or cultural environment**

In order to answer these questions the best way possible, separate sections have been developed in this guide to make sure that the most frequently asked questions are answered in the most accurate framework. Therefore, the general term of "environment" has been avoided, and the most specific terms of "family" and "social factors" have been used. The previous section covers the characteristics of the family system that typically emerge in the histories of anorexics, bulimics, and bulimarexics.

For information about the social factors that impact on the onset of these eating disorders, please refer to the section on

"Social Factors", which follows directly below.

Part VI

SOCIAL FACTORS

ANOREXIA, BULIMIA, AND BULIMAREXIA

"The Impossible Dream"

"I always wanted to look perfect. And you know what perfect looks like. Straight nose, thick hair, wide-set eyes, full lips, the whole number. But the big thing was always to be thin.

"When I was little, I used to sit in front of the TV and eat snacks and stuff that I snuck into the house when my mother and father didn't know. They killed me, just about, when they found out. They punished me for a week, saying that I couldn't watch TV because I disgusted them by giving in to my impulses.

"I agreed with them. I was disgusting. Sitting there, soaking up calories like a pig.

"I wish I could be like those models on TV or in the magazines. They have those tiny hips, and little waists, and everything looks so good on them. Clothing hangs just right, and you never see a woman on a TV show, or in a magazine, who is anywhere near successful who isn't thin and pretty.

"I know that those girls have to really try to look good. They don't sit around and stuff their faces, so I have been working really hard at being just like them. I took up ballet, even though I'm already 14 and there's no way I could really make a career out of it. My mother and father thought it would give me

the grace and the discipline that they say I don't have.

"I guess they're right, because my dance instructor says I'm doing really good on my diet.

"To be honest, the diet makes me feel physically sort of sick, because I do try really hard to get rid of calories that I take in. I'm better at dancing when I don't weigh as much, so I usually either throw up, or take diet pills, so that I'm really super-light now when I dance. It's important to be light, my dance instructor says, especially for the girls."

The young woman who is described above is fairly typical of the bulimics who are becoming more and more common among junior high school, high school, and college populations.

Let's listen to another young woman, who is several years older.

"When I started to binge and purge, I felt like I had died and gone to heaven. Or at least gone to purgatory. I knew that there had to be pain to have any kind of gain, and I was determined to gain a certain boy in the class.

"When we started dating -- that was ninth grade -- he happened to mention that another girl who was trying out for the tennis team had really great legs. I looked at her legs, and then I looked at mine. Mine looked like two tree trunks! Right then and there, I knew I had to lose those tree trunks, or lose my boyfriend. And my boyfriend was the most popular boy in school.

"Binging and purging has been a really good way of maintaining my weight, while still eating what I want. But lately, I've

been feeling pretty sick.

"I've been reading all sorts of books about dieting, so that I could sort of change over to a different way to manage my weight, since I know that throwing up and taking all sorts of diuretics and laxatives is really bad physically. The problem is that I just haven't found that way yet. I just can't seem to stop the whole binging and then vomiting cycle that I've gotten used to.

"No one knows, by the way. My mother and father think I look great. And I am a perfect size 6, so I'm not looking like a skeleton, like the anorexics that you see in magazines and stuff. Everybody knows that you have a better chance of getting a man, and getting a job, if you look right. And all you have to do is check the TV or the magazines to see what it means to look right in the 1980's.

"You can have all different types of hair and even skin color, but you have to have a good figure. You just can't fit the image if you can't fit your jeans."

A young woman who had been anorexic, and had recovered, still reported that her greatest satisfaction came when someone complemented her on her figure. Now that she had erased the skeletal version of herself, and her therapist had helped her to stabilize her body at an appropriate and healthy level, she still considered herself at risk. Her story is a vivid illustration of the effects of social pressures and cultural expectations on the

personal development of a young, middle-class woman from an Italian family.

"I know that my parents wanted a boy because they set my room up in blue and they always gave me nicknames that would have been better for a boy. Of all those names, Nikki stuck, even though it has nothing to do with my real name.

"Ever since I can remember, my mother and father would take pleasure in telling the story of the pediatrician, who greeted me when I came into the world, and who called me his "little elephant". From the day I was born, they had me on a diet.

"Basically, the theme of my growing up was that I was not a boy, so I had to take particularly good care of my body. The competition was really bad when it came to finding a decent man, and they were not going to let me marry just anybody. They would decide when the time was right for me to start looking for Mr. Right.

"I became anorexic when I was about 11, and I was successful in stabilizing my weight in therapy after I was 18 years old, and I had left home. I have a really good job now, even though I never did go to college and my salary is terrific.

"I am in charge of a division of a computer sales and service company, and this year I received an award for selling the greatest number of units in the whole country. It was the best day of my life, and my parents even came to the dinner that was given in my honor.

"Intellectually, I know that the honor that I earned was absolutely the best thing that could have happened to me, professionally. But when my mother told me that I had really kept my

figure great, I felt better than if they made me president of the company.

"God help me. I know I still have so much to work out."

Nikki had learned in therapy to be often brutally honest herself, so that she could understand what specific needs and feelings motivated her to behave one way or another.

In reviewing the three cases that we have just touched on here, it is possible to isolate just about all of the special social pressures that have made such an impression on the young women such as those we have described.

You can probably develop a list of the social pressures just by reading the excerpts above, but we'll give a basic list for you to use as a guide.

The Culture of Dieting. Sociologists in the future might look back to the 1980's and call it the decade of the salad bar. In this decade, and in the preceding twenty years, American people, in general, and American women in particular, have become increasingly aware of the healthful properties of a low-fat, low-salt, low red-meat diet.

Eating salad for lunch, with perhaps a sparkling water for a drink, has become not just "de rigeur", but expected, particularly among women. Almost everyone is on a diet, and no matter what a particular woman weighs, it seems she always wants to weigh 5 or 10 pounds less.

Why all the interest in losing those few pounds? Why do American's attach so much significance to that weight loss that

the majority of women would rather lose 10 pounds than receive a promotion or earn more money, according to a recent poll in a national women's fashion magazine?

The answer is that Americans truly believe that women are more desirable, more successful, and more valuable if they are thinner. Weight loss carries with it the promise of new or renewed romance, personal achievement, social recognition, and respect. It seems that weight loss is attached with such important properties that it rivals formal education as a means of achieving social and professional goals. And the pressure is the greatest on women and girls.

Consider the following scenario. If weight loss means success, then the opposite is also true: weight gain means failure. Girls or women who weigh more than a chart on a doctor's wall says they should weigh are somehow implicitly guilty of failing themselves and those who love them, because the evidence of their lack of self-control is obvious in their hips, waists, and round faces.

Salads and optimal weight maintenance are certainly potentially good things. However, ask yourself if it is good to eat only salads? If you eat only salads, how much protein do you consume? What is in those salads? Do you have cheese? Meat? Or do you just eat what the saladbar offers?

Now, many colleges and high schools offer salads as an option for a meal. What is in those salads? Is there enough protein to grow and stay healthy? You can see that once you begin to ques-

tion a cultural characteristic like dieting, all sorts of assumptions and beliefs start to crumble.

The culture of dieting is strongly reinforced by the billions of dollars that the diet-related industries pump into the commercial market every year. Think about how often you see the word "diet" in any given day. You see it on books, magazines, guides to better living, guides to business success, newspapers, television, and you hear it all the time on the radio.

The promise of the diet is simple. If you diet the way a book or a method suggests, then you will be happy.

Happiness is a powerful promise, as full of expectations as it is with disappointment. After all, you are who you are. No matter what you look like, what color you make your hair, or what new clothing you might put on, you cannot escape the fundamental things that make up who you are at any given time in your life.

If you make your body shape new and different, and you have not faced any of the impulses or pressures that made you gain weight in the first place, the promise of the diet echos with a painful, hollow sound when you put that weight right back on.

You've seen it all the time. People you know and care about who believed in the culture of the diet, and who followed the rules, gained the weight back over time. Why? Because the diet tricks do not change what makes people weigh more than other people. Only careful change and understanding of life circumstances can make those permanent changes. And there is one point you really do not want to miss.

If you diet for someone else, or you diet to attract love or

approval, then it is likely you will be crushingly disappointed at some point. You might gain back your hard-won losses. Or you may develop an obsession with food, thinking about eating and worrying about eating too much.

There is no more perfect map to follow if you want to develop an eating disorder such as anorexia, bulimia, or bulimarexia. Food becomes the focus of life itself, and suddenly you may find that you, or someone you care about, has let life take a back seat to worrying, planning, and thinking about food.

All this reading may make you wonder why there is so much pressure on women in America to be thin. Why do the women worry about food more than men? One of the most frequent questions that came up when people were asked to raise whatever question they wanted was the following:

Why does it seem that women worry about diet and food more than men?

The answer to this basic question is really the heart of the problems of anorexia, bulimia, and bulimarexia, at this time in the history of America.

A very simple answer would start with this statement: Women have traditionally been in charge of food. They have cooked, and prepared, and chosen the food that has sustained the family and made women pleasing and successful to the family, the community, and the culture.

This is typical of some cultures more than others, but there is no avoiding the basic fact that women have traditionally been encouraged to learn about food, and to develop the ability to prepare food in an attractive, nutritious, and economical fashion.

Why have women traditionally been expected to develop these skills? Because women have traditionally worked in the home. The economic system typical of the United States and many other cultures is based on the marketability of male talent in the market place, and the marketability of women to men.

You know the old saying, the way to a man's heart is through his stomach. Women who wanted financial security had to make themselves physically attractive, as well as proficient in the art of making the house a home. One of the steps to making the house a home was preparing food.

The problem is that women are associated with serving food. Not eating food. Particularly in the past twenty years in the United States, women were expected to preserve a youthful appearance, and youthful meant slim or thin.

When our society tells women that they are the source of food and nurturing, and simultaneously tells women that they are not entitled to gratify themselves by feeding themselves the way they feed others, the society is guilty of giving women mixed messages.

A mixed message is one that carries conflicting commands which cannot really be accomplished with equal success. So the mixed message confuses, worries and undermines women, and has the built-in feature that threatens the woman with failure, no matter how hard she tries to succeed. You just can't win if you play for two opposing teams.

You may argue that many women and men are seeking and finding non-traditional roles that shake up the assumptions of the past. But the fact remains that the women and the girls of today are

still living in a time when the majority of people still find that women are responsible for taking care of the family's food needs, even if the woman also has a job outside the home; and the majority of women still are economically less successful than men who have equivalent years of education and training.

So women still have to make themselves more attractive and more competent if they are to attract a man. And the way to a man's heart is through his belly, not the woman's belly.

The role of the woman is once again reduced, so to speak, to that of the attractive and home-based reflection of the man's success. A well-fed man might pat his belly if his wife feeds him well. But if a woman starts to pat her belly the same way, she starts to worry that her husband may start to pat a woman whose belly is not so round.

Right here is the place for the next most frequently-asked question regarding the socio-economic considerations that effect the development of eating disorders, such as anorexia, bulimia, and bulimarexia. That question is: **How important is the media in encouraging women and girls to be very thin?**

It is likely that we cannot begin to estimate how important the media is in driving home the point that women who are successful and desireable are also thin.

Look at the advertisements for any product. Jeans. Make-up. Floor wax. Beer. Lawnmowers. Automobiles. Soda. What do all these products have in common? Thin women.

The men are not necessarily thin. In fact, some very heavy men advertise some very important items, and their scripts do not necessarily include making fun of themselves, or acting foolish.

But look at the commercials with heavy women. The heavy women are making fun of something or someone, and they are supposed to be getting a laugh.

Print media, visual media, and radio all reinforce the same basic points: successful women are thin women. There is no such thing as an overweight cheerleader, a heavy super-mom, or picture of a bride who is anything less than slender.

If you tend to dismiss the power of the media, ask yourself the following questions. Do you wear things that are currently in fashion in your social group? Do you buy name-brand products? Do you feel that certain products are inherently better than others, even if you haven't tried the others, and the others are less costly?

Do you feel that the news is more or less what you hear and see and read? Are your political feelings effected by the news reports? And do you agree that the women who are on the magazine covers and the TV advertisements are more beautiful than other types of women who will never be on those covers?

Then you are deeply effected by media. And you share a common bond with the women and girls who see and hear the media messages, and are profoundly effected by those messages.

You know that media is powerful, just by the simple fact that the advertising industry pours billions of dollars each year into media campaigns. Manufacturers, distributors, and advertisers literally bank on the ability of the media to make you buy a product, or buy an image.

One of the most successful images projected onto the American public has been the image of a thin woman, whose thinness is equated with beauty, success, sexuality, and the ability to win where other, heavier women fail.

But why is it that some women and girls develop this problem, and even some men and boys develop eating disorders, and others do not?

For the answer to this question, you need to refer back to the section covering psychology and family systems. No one would suggest that seeing a commercial over and over again would necessarily change a person's values or attitudes toward his or her physical self, or toward others.

However, it is reasonable to suggest that there is a relationship between the psychology of the individual, the pattern of family relations and roles within the family, and the effect of the media.

Take the example of Marsha. Marsha was 13 years old when her parents suggested that she go on a diet. When Marsha was told to do something, she generally did exactly what she was told. She did not have many friends, but her one best friend, who is one year older than Marsha, became pregnant the year that Marsha turned 13.

Marsha was devastated by this event. Her friend had gotten pregnant after dating a young man only a few times. It seemed that the two girls had gone to a party, and Marsha stayed at the party while her friend and the boy went off alone for awhile.

At first, Marsha had thought the dating was exciting, Her

parents did not allow her to date, because they said she had to make sure she only went out with boys who deserved her company. It was fun to watch and learn what her friend was going through. It was like seeing a preview of the future, according to Marsha.

But the preview had a very frightening part. Marsha decided that her parents were right. It was scary out in the world, and she had better make sure that she was eventually ready by being perfect in every way. She basically felt that perfection would protect her from inadvertent and foolish errors in judgement.

Marsha studied her fashion magazines carefully, choosing current styles that downplayed her rapidly changing body but still looked fashionable. She went on a series of diets, each one more restrictive than the other.

At Thanksgiving, Marsha helped her mother prepare an elaborate feast, just like the one that they showed on the soap opera Marsha and her mother watched at night. And she said that she was just like the women in the soap opera -- she would just make sure everyone else ate well, but she would not eat anything herself.

Everyone at the table praised her for her willpower and her will at providing for others. And each member of her family pointed out that someday she would make the right man very happy.

That holiday season, Marsha earned a 4.0 grade point average. Her parents were pleased, but no one made a point of talking about it at the table. No one shared this information with the other relatives, even though Marsha had made the dean's list, and the principal had selected her as Student of the Month.

You could argue that Marsha was an excellent student inside

the classroom as well as outside. She studied the messages from home, from the media, and she studied the threats that existed outside the family system. She decided that the rest of the world was right. A girl should be good at all things, in order to achieve enough to earn the attention of a good and decent man, who would take over the role of taking care of the girl when the family system no longer could or would do so. Within one year, Marsha was anorexic.

Marsha was the typical anorexic product of a middle class or upper-middle class family where the values of the home were reinforced by the values stressed in the media. Marsha's growth and development was deeply effected by her anorexogenic family system, but there were other things that happened to Marsha, as well. She suffered a traumatic experience when her friend became pregnant.

Although Marsha certainly did not suffer directly from the specific problem, the fact that her friend, who she picked out, was capable of such undesirable behavior frightened Marsha. She started to doubt her ability to pick out people who were good for her, and this doubt confirmed her family's message that she was essentially not smart enough or independent enough to make social choices that were safe and good for her.

Social factors, psychological problems, and family system issues are not the only things that contribute to the development, identification, and treatment of anorexia, bulimia, or bulimarexia. There are special, specific medical issues that many people have questions about. The most commonly asked questions about medical

problems and the onset of these eating disorders will be covered in the following section of your guide.

Part VII

MEDICAL ISSUES

WHEN BODIES DO NOT GET THE RIGHT FUEL

Jenny could not understand why it was that her sister had so many medical complaints. She was always at the doctor for one problem or another, but she never seemed to get cured. She was not surprised, then, when her sister was admitted to the local hospital for tests, because she was suffering intensely from stomach pain and from headaches.

Jenny might not have been able to understand because she did not draw a connection between her sister's sudden and drastic weight loss, and anything that could possibly be going wrong physically. After all, Jenny reasoned, why would someone be sick when they did the healthy thing, and lost weight. This sickness was a contradiction in terms, according to Jenny's point of view.

Obviously, her sister agreed. Her sister, whose name will be Janet for the purposes of this discussion, was anorexic when she was admitted to the hospital for tests. Her doctor did not diagnose her, though. He simply chose to admit her for tests.

Her doctor was the family pediatrician. The parents still took Janet and Jenny to the pediatrician, although both girls were in their teens. Neither one of the children had ever seen a

gynecologist until Janet stopped having her period. When Janet pointed out that her period had not come for three months, her mother took her to her own gynecologist, who had, incidentally, delivered both Janet and Jenny. He prescribed hormone pills, and sent them both out the door with a cheery remark about how teenagers often go through stages when their hormones are really out of balance.

The hormone pills did not stimulate the period, and Janet's mother took her back to the pediatrician. Since Janet had so many serious complaints about physical pain that the doctor could not locate under the limited opportunities available for testing and examination in the office, he admitted her to County General.

The above circumstance describes the first doctor-contacts that are typically made between the anorexic, the family, and the medical profession. The anorexic's physical complaints are often complex and potentially linked to a host of medical problems.

The pain and the medically-related complaints presented by the anorexic are linked to the anorexia, and the same goes for the bulimarexic and even the bulimic. However, in the case of the bulimarexic or the anorexic, the patient will suffer the indignity, pain, and general convenience of endless testing and hospital stays, as all sorts of specialists seek to identify what the medical problem might be. The point of this section is to help you learn how to answer the single most commonly-asked question about the medical issues surrounding the eating disorders that are the subject to your guide.

What are the medical complications that can develop when a person starves herself or when a person goes through bingeing and purging?

The list of symptoms is available directly below. You need to know, however, that these symptoms are not always connected with anorexia, bulimia, or bulimarexia. So if someone you know and care for announces that the doctor said he or she was suffering from stomach cramping, for example, it is not necessarily from bingeing and purging, or from self-starvation. The problem could be tension, and could be entirely unrelated to eating disorders.

Now that you understand that point, you are ready to understand the rest!

CARDIAC ARREST

That's right. The heart can simply stop beating. This can happen in a highly-progressed anorexic, who weighs thirty pounds below normal for her height, or it can happen to a bulimic who seems to be a perfect weight, but who has developed chronic, habitual bingeing/vomiting/purging behaviors.

Frightening? You're right. People who are anorexic, bulimic, or bulimarexic also tend to heavily abuse laxatives and diuretics. Laxatives loosen your bowels, and diuretics drain you of excess water.

If you are constipated from time to time, or if you retain water at certain times in your life, doctors may prescribe medication for you, so that you can experience relief. Or you may use over-the-counter medications that achieve the same results.

However, people suffering from eating disorders such as the

ones you are reading about here abuse laxatives and diuretics. If one small tablet brings you overnight comfort for constipation, imagine the result of taking 50 or 75 or 100 tablets, every day, all the time. Your body would never have an opportunity to work on its own. Your gastro-intestinal system would suffer extensive and often irreparable harm over time.

The same is true of diuretics. The body has its own way of releasing excess fluids, in its own time and at a pace that is usually healthy for you. If you take dozens of diuretic pills every day, then you get much more than just weight loss. Your skin can become chapped and hard, your eyes can suffer damage, your body's ability to maintain normal temperature by perspiring is reduced, and you can suffer permanent organ damage. For example, you can destroy your kidneys.

But cardiac arrest can develop if you abuse laxatives, abuse diuretics, and/or vomit continually. In fact, if you are not an-orexic or bulimic, and you decided to try to take 100 laxatives, or 50 laxatives, or 550 milligrams of diuretics, you might well suffer immediate cardiac arrest. Your body simply could not sustain the traumatic effect of that kind of purging.

CHEMICAL DEPENDENCIES

If you take over your body's ability to decide when you have to urinate or defecate, then after a period of time, your body will not know how to make those choices. You will have to take laxatives and you will have to take diuretics.

Basically, you will not be able to urinate on your own be-

cause the kidneys will lose their ability to regulate any water-sodium flow. You will have forced your kidneys into a condition where there is such a constant onslaught that they are unable to manage the pressure.

Naturally, the same problem develops in its own fashion, when you abuse laxatives. If you do not allow your body to decide when it is ready to discard waste, then the colon can be damaged very seriously. In fact, after chronic abuse of laxatives, anorexics report symptoms similar to colitis. The colon essentially becomes spastic.

It is evident that many bulimics and anorexics abuse other substances as well as laxatives and diuretics. They will often abuse alcohol, which has a deleterious effect on the gastrointestinal system, the cardiovascular system, and the kidneys and liver. And they will often abuse other mood altering substances, because they frequently suffer from depression. This problem is discussed further below.

VITAMIN AND MINERAL DEFICIENCY

Naturally, if you do not eat balanced meals, and you do not use vitamin supplements for specific needs, then you will suffer from vitamin and mineral deficiencies. The degree of the deficiency can vary from individual to individual, but anorexics and bulimics, and bulimarexics, suffer continual and accelerated deficiencies that undermine their ability to live at all.

For example, potassium is usually deficient in the system of bulimics and anorexics and bulimarexics. That is because po-

tassium leaves the body when the body is constantly flushed, through vomiting, laxative abuse, or diuretic abuse.

You may never have really thought about your own body's need for potassium, but you do need potassium in order to maintain a strong body and a good frame of mind.

When you lose potassium, vitamin C, vitamin A, B-Complex, and the other vitamins and nutrients that are available in food and in supplements, then you lose your energy. If you feel lethargic, you can associate the feeling with the onset of depression. And an anorexic or bulimarexic or bulimic can go to a doctor or a therapist, complain of depression, and receive treatment for depression without anyone focusing on the fact that the depression is symptomatic of the eating disorder. The eating disorder not only depresses the people because the victims are ashamed of their behavior, or they feel that others treat them badly, but because they lose the fuel that they require to get through a normal, active day.

SMILE DAMAGE

The medical doctor is not the only one that the anorexic may visit on her or his rounds for treatment of symptoms. The dentist's office is ultimately unavoidable for anyone who purges by vomiting. This office visit is spurred by a variety of dental problems.

First of all, the body suffers calcium deficiency. That deficiency manifests itself, in part, in the teeth.

Not only is calcium deficiency a problem that can cause bro-

ken, weak, or otherwise damaged teeth, but the acid that is part of the vomit literally can take the enamel off the teeth.

If you vomit often enough, you will actually remove the enamel from your teeth. That is a particularly cruel side effect of a disease that often begins because of a person's desperate desire to fit into a conventional description of female beauty.

SEIZURES

There is evidence that demonstrates that self-starvation and chronic vomiting/binging/purging can contribute to the onset of seizures that are similar to those of the epileptic. The reason for the seizures is the same as that reason that causes the normal-weight, non-bulimic epileptic to suffer a seizure: brain waves are disturbed.

Neurological damage, resulting in disturbed EEG patterns when brain wavers are charted, has been connected with laxatives and diuretic abuse. The rationale for this connection seems to lie in the fact that blood fluid and electrolyte imbalances cause what is best described as disturbances in the brain. These brain disturbances are picked up by devices that measure brain waves, and the result is profoundly disturbing.

So far we have demonstrated that what might start as a desperate effort to assert some control, or an equally determined effort to diet, can become a matter that involves life itself: heart damage; kidney damage; liver damage; damage to the gastrointestinal system; and even brain damage.

SPECIFIC GASTROINTESTINAL PROBLEMS

You know already that when you eat too much you have to loosen your belt. That means that your stomach is somewhat swollen, or extended. Well, if you eat so much that you literally hurt from eating, then you may expect your body to be extremely swollen. In fact, it is possible to cause severe strain or even rupture of the intestine from binging.

The efforts to vomit can cause the esophagus to bleed, and to be permanently irritated. It can even cause permanent damage in the form of a ruptured esophagus.

THE LIST GOES ON

As you can imagine, the list of potentially damaged organs and parts of the body can go on indefinitely. The musculoskeletal structure is eroded, and the victim ultimately can become seriously weak.

Everyone can agree that failure to ingest food and drink can cause the body to slowly and then rapidly sustain serious, even irreversible, damage.

Forcing the body to undergo the violence of both binging and purging adds to the insult of starvation, or simply takes its toll on its own.

In any case, the outcome is the same. The individual who tried so hard to take control over the body finds that the body abandons the owner when the owner abuses that body. Ultimately, the effect to achieve beauty can result in the erosion of the most lovely aspects of a given person: her hair, her eyes, her smile, skin, hands, nails, and her brain.

A FINAL WORD ON THE TOPIC OF MEDICAL PROBLEMS

The young woman who you read about in the beginning of this section was typical of the anorexic, bulimic, or bulimarexic. The victim of one of these disorders will go through all kinds of office visits, hospital stays, and invasive, painful examinations of the anal, vaginal, and other orifices to determine the etiology of symptoms. During all of this difficult assessment, the victim will almost never volunteer that the tests are unnecessary, that she knows what is wrong. Anorexics, bulimics, and bulimarexics are notorious for their ability to deny their behavior to anyone at anytime, if they feel that the person will try to stop them from their intention to continue to starve, binge, and/or purge.

The unwillingness of the victim to admit the nature or the reason for the physical symptom is all the more reason why it is essential for us to understand as much as possible about the clues that show a young person, or an older person, who might be inclined to develop anorexia, bulimia, or bulimarexia.

Part VIII

HABITS AND BEHAVIOR

Mr. Gentile's greatest regret regarding his daughter's bout with bulimia was that he did not recognize the signs. He asked specifically that this guide include the answer to the most frequently-asked question of all.

How can a person's habits or behavior indicate that they are al-

ready sick, or likely to become sick with one of these eating disorders?

The best way to answer this is to give you a check list. You can xerox this check list and leave it in doctor's offices, schools, and anywhere else that you think people need to know more about this epidemic range of disorders.

— PECULIAR EATING HABITS WITH EMPHASIS ON DIETING

(That means that the individual will keep very meticulous and copious lists of good foods and bad foods, and the bad foods list will be much longer than anything you have ever seen in an ordinary diet book.)

— MORE THAN ONE WEIGH-IN A DAY

— ADDICTED TO EXERCISE: CANNOT SIT STILL FOR FEAR OF RETAINING CALORIES

— TALKS CONSTANTLY ABOUT FOOD AND EATING

— FOOD REFUSAL EVEN WHEN NO FOOD INTAKE CAN BE ACCOUNTED FOR IN A FULL DAY OR MORE

— USE, AND EVENTUAL ABUSE, OF LAXATIVES AND DIURETICS, SUCH AS DIET PILLS AND AMPHETAMINES OF OTHER TYPES

— CONTINUED EXPRESSION OF ANGER OR DISGUST ABOUT PERSONAL WEIGHT PROBLEM

— EXTREMELY DISTORTED BODY IMAGE: SEE FAT WHERE THERE IS ALMOST NO MUSCLE LEFT, MUCH LESS FAT

— LOW SELF-ESTEEM

— ANGER THAT IS HARDLY EVER REALLY EXPRESSED ALOUD

— IRRATIONAL AND DEFENSIVE THINKING

This is a check list that you can use to decide if you or someone who you care about is suffering from an eating disorder, or if they might be a candidate to develop an eating disorder.

Naturally, if you use the information offered in the previous sections, you will be able to develop an even clearer picture of the habits and behaviors of the victim suffering from anorexia, bulimia, or bulimarexia. You will want to look for a lack of self-confidence when faced with the need to make independent choices. You should also be alert to a family system that makes it impossible for a young person to grow away from the home in a timely way.

All of these signs point to the potential for onset of one of the eating disorders that have been discussed in this guide. You do not necessarily have to constantly notice every little change in weight or behavior, particularly during adolescence, since adolescence is a period of considerable, rapid, and often contradictory change. The point here is that if you understand the basics, you will be alert to the signs, if the signs are there.

You have just absorbed the basic, important information that anyone needs in order to be able to tell if someone is developing anorexia, bulimia, or other related eating disorders. However, just because you know this basic information does not mean that you will always be able to tell if the people you care about are suffering from some of these problems. •

Naturally, over time, you will be likely to know if someone is developing anorexia, because of the serious weight loss. The same applies to bulimarexia. But you may even live with someone

who is bulimic, and not know. The person's weight could stay basically the same, and you may not pay very much attention to changes in their eating habits.

The most important thing you can do is avoid falling into the guilt-trap. The guilt-trap opens up and swallows the people who feel guilty for having the disorder, and the people who feel guilty because they did not succeed in helping the person they cared about to overcome their eating disorder.

Guilt never changes the situation. It cannot help the person overcome the problem, and it cannot help the friend or relative to help the victim. In fact, the only thing guilt can do is make more victims.

How do you help yourself, or those who you care about? You can encourage them to become involved with any one of the treatment approaches that have been developed to help anorexics, bulimics, bulimarexics, and the family's of those victims. You can find out the basic information about the different types of treatment approaches, by reading the following section of your guide.

Part IX

TREATMENT APPROACHES

Yes. There are people who entered into therapy for the treatment of bulimia, anorexia, or bulimarexia, who do not suffer from self-starvation, bingeing, and/or purging anymore. That means that the question asking "Can people who are bulimic, anorexic, or bulimarexic be cured," is essentially "yes".

The key to understanding the nature and the purpose of treat-

ment is to remember the most important feature of any of these eating disorders: they are all psychological problems, in the vast majority of cases. There may be many physical symptoms for those psychological problems, and many times the victims and family, and friends, become very involved in trying to help the victim get rid of the symptoms. The problem with that approach is that extinguishing symptoms does not necessarily mean that you have also extinguished the root cause.

Various treatment approaches have been found to help anorexics, bulimics, and bulimarexics in many cases. These treatment approaches often involve family therapy, as well, if the victim is living at home with parents, or is married and living with a spouse and perhaps children, as well.

This section is only meant to answer the questions that most people ask about treating the eating disorders that have been covered in your guide. You are not expected to be an expert on treatment, or to be the one to decide which treatment approach would be right for someone else. However, if you should have to make a decision about treatment for yourself or someone else, you will know a great deal about your options, just by reading through this short section.

Each part of this section has been developed in answer to the most often-asked questions regarding treatment for eating disorders. In each case, there is a note as to whether the treatment is good for anorexics, bulimics, or both.

A. IN-PATIENT CARE

"My friend from school is in the hospital now, because she starved

herself so badly since she has become anorexic. Is hospital care good for people who are anorexic?"

Hospital care can be good for a person who is suffering from a great many problems associated with anorexia. Those problems could include starvation, as well as the host of medical disorders and symptoms that are covered in detail in the section discussing medical problems.

There are people who feel that in-patient hospital care is pointless for anorexics, because the anorexic will simply be stabilized in the hospital, and then continue acting self-destructively after being released.

This complaint was typically raised by professional people who saw how anorexia was treated in hospitals that had no special unit to provide the care that anorexics might need. At this point, however, there are many hospitals that have incorporated treatment for anorexic patients into their overall treatment programs. In addition, there are hospitals that offer special units, where the only members of those units are people who are suffering from anorexia, and people who have been specially trained to help those patients.

In either case, hospital care can help the patient achieve the first critical step in any successful therapy program for anorexics: enough weight gained to be considered out of imminent danger of loss of life.

In fact, many therapists and doctors agree that therapy of any kind can be ineffective if the patient is dangerously underweight. If, for example, a patient starts to see a psychothera-

pist on an office visit basis, but continues to lose weight, the psychotherapy can become completely unproductive. The major symptom, which is the dangerous weight loss, interferes with the treatment. Patients who are too far below normal or original weight can be either too weak, or simply too troubled by other symptoms, to respond positively to out-patient care.

Therefore, most in-hospital programs offer a patient a combination of feeding and psychotherapy. Medication may also be administered, so that the patient can feel better and remain in more positive control of what happens to her or him.

There are people who argue that in-hospital care, or forced treatment, such as feeding, is a violation of the patient's rights. However, consider the following scene. You see someone you care about standing on a train trestle, waiting for a train. You realize that she is trying to kill herself. Do you turn your back? Or do you take whatever steps are in your power, without losing your own life, to help her save her own life?

This is a moral debate, and there are people who would say that she has the right to take her own life. However, it is also possible to argue that people who show the world how they are trying to die are actually screaming desperately, if silently, for help.

If your friend or relative was on the tracks, and screaming for help, there would be no question that you would do everything you could to help effect a rescue.

This is the type of reasoning that is essential, if you consider how hard it might be to place someone you care for in the

hospital. What are your choices? When the person you care about is anorexic, and is continuing to lose weight, then you may have no choice.

The actual treatment in hospitals can upset people, because there is forced feeding. But this is not a violent event. The patient is medicated, just as patients are medicated in order to make sure that they will get the most benefit out of other types of treatment for other medical or psychological problems. The point of hospitalization can be simply to stabilize weight and to provide a solid basis for the out-patient treatment.

The worst thing about having a friend or relative placed in a hospital for treatment for anorexia is coping with the patient's pressure to get her, or him, out of the program. Anorexics are intent upon self-destruction. They may complain, lie, and try to divide and conquer friends, relatives, and treatment personnel.

Think of this type of resistance as the way your friend might behave if you were pulling him or her off the tracks of an on-coming train. He or she might resist very strongly, but will be alive.

The prevailing point of view is that where there is life, there is reason for hope. So if your friend or relative complains that the hospital personnel have fed her intravenously, or have been feeding her through tubes, you can consider their actions identical to placing your arms firmly around your friend, and literally pulling for dear life.

B. OTHER TREATMENT

"If a person suffering from anorexia or bulimia has reached a

level of basically healthy weight, what types of treatment are available? Which are the best types of treatment, out of all the options?"

Just like all other therapy, best is usually defined by what works for an individual person. Therefore, this guide will not offer any judgements on the major types of therapy that are available. Just keep in mind that treatment for one person you know might or might not be good for another person you know. Psychotherapy is a very individual thing, in many cases, and the individual therapist may or may not be the best for you or the person you care about.

But if you are disappointed or concerned about what an individual therapist is doing, remember that you can always seek out an opinion from another professional person.

These rules for judging what is or is not best apply to so many life situations that you will be very well practiced at searching for the right person, if the need should arise. The right treatment approach will probably be one of those described briefly below, or it could be a combination of several types.

Family Therapy

"Why does my whole family have to go to counseling because my sister is anorexic? I think it's a waste of time because it's just my sister who is sick."

Very simply, no individual becomes anorexic alone. The family system is closely tied to the decision of one family member to become anorexic. In fact, the family can also play a large part in the decision of a family member to become bulimic.

Marissa G., whose sister was anorexic, found out that family therapy was important when her sister, who had done well as an in-patient, immediately fell back into her old, essentially suicidal pattern of bingeing and purging when she came home.

If a patient is living at home with parents and perhaps siblings, as well, then family therapy is often the only route available for everyone to find out how they might be contributing to the onset and entrenchment of the disorder. Once everyone has an idea of how they contribute to the problem, it is possible for people to change their attitudes and behaviors in the family.

Some family therapists come to the family home, and get very involved in helping the family basically rearrange the way each member or group of members interacts with each other. Other family therapy might take place in the therapist's office.

This type of approach to treatment is readily available. And it can help the entire family, as it helps the anorexic. Family therapy can be equally effective when the problem is bulimia. Bulimics and their families can suffer terrible conflicts and arguments about food, personal behavior, eating patterns, and other problems that are part of the bulimic's problems, and part of the family's problems. The family therapist can do for the bulimic and the family the same thing that he or she can do for the anorexic and the family: help the entire family to reorganize relationships and behaviors, so that self-destructive energy is converted to productive energy. The outcome can be very effective for all people suffering from the full range of eating disorders covered here, in your guide.

Family therapists can use various methods of family therapy, and can also incorporate some of the following treatment approaches into their overall treatment plan. And remember, sometimes family therapists, who do their work in the home or in their office, may have to work in cooperation with a hospital, when in-patient care is necessary to help bring a patient to the point of being able to respond to out-patient care, such as family therapy.

Some hospital treatment programs do offer family therapy as part of the care package offered to the patient. However, this type of progressive and positive treatment is not always available.

Individual Therapy

"My therapist saved my life. I know now that the best thing he could have done for me was make me stabilize my weight, and interact with the rest of the world."

For the patient quoted above, interacting with the rest of the world meant becoming involved in a volunteer program for geriatric patients, which was based in the same hospital where her parents first brought her when she was 19 years old.

Today, this patient is functioning very well. She has maintained a healthy level of weight, despite her 6 years of bulimarexia, although she does have certain health problems as a result of the years that she abused her body. However, she is planning a wedding as this book goes to press, and she just earned her Master's in Social Welfare. At the age of 28, this young woman has her future.

Bulimics, anorexics, and bulimarexics tend to require dif-

ferent types of behavior change and insight therapy. All of these treatment groups do demand help in dieting, so therapy usually has to incorporate some method of working with weight, but the trust of that method must be weight stabilization and maintenance, not weight reduction per se.

All individual therapy is designed to help the individual change her or his body image, and to alter the view that the physical self is the only arena where the patient can assert some manner of control. The therapist usually tries to help the patient to separate from others, to define personal goals and objectives, and to conduct ordinary problem-solving sessions, so that the patient can see the good and the bad aspects that are usually part of every decision.

Problem solving, crisis intervention, body-image change, and enabling the patient to define goals and objectives separate from the people who have been controlling the patient's life throughout, are all part of the goals of insight therapy. There might be different ways to achieve those goals, and there are certainly different methods of individual therapy, but all are intended to help the patient to achieve control over and insight into positive life choices, instead of control over what amounts to long-term self-destruction.

Group Therapy

"Once I became involved in group therapy, it was like I walked onto planet earth after spending ten years alone on the moon. Suddenly, I wasn't alone anymore!"

Bulimics, anorexics, and bulimarexics have reported similar feelings about becoming involved in group therapy. Like the rest of us, finding out that there are other people who have the same problems can be a source of great comfort. Group therapy can be conducted on an in-patient basis, or can be part of the out-patient treatment offered by many private practitioners.

There are many different types of group therapy, ranging from groups that are tightly controlled by the therapist to groups where the therapist plays a much less controlling role. The type of group is usually a very personal decision, and people will seek out the type of structure that they need, in many cases. If not, the therapist will frequently recommend that the patient seek an alternative treatment approach, since there might be too much or too little structure in that particular group.

The important thing to keep in mind is that trying means sometimes not succeeding. The first group may not be right for the individual. It may take some shopping around. But the right group can be found, or even formed, to meet the needs of patients who require care on an in-patient and/or out-patient basis.

Clinical Biofeedback Therapy

One of the best things about biofeedback therapy in treating anorexia or bulimia is that the treatment brings the patient very much in touch with her or his body. This can help correct that profoundly disturbed body image that is part of all of the eating disorders covered in this guide.

Anorexics and bulimics also enjoy the sense of personal con-

trol that biofeedback gives them. They are able to tap into their own bodies to find when they experience stress, and how they can reduce that stress.

This particular type of therapy also offers the patient the opportunity to focus on a third object, that being the instrumentation. It has been demonstrated that teenagers, in particular, like the equipment and are attracted to the feedback they receive from the various machines.

Aside from this, the machines can usually help to refocus the patients attention, leading to increased self-control and discussing problems. That is one of the fundamental appeals of the biofeedback approach, particularly with patients who are younger, or more resistant.

However, older patients, in the twenties and beyond, have also achieved treatment results through this type of therapy. The older and younger patients are often very responsive to a tool that can visibly demonstrate how the things that they feel make them react, physically. Since these eating disorders are psychological problems that are expressed physically, biofeedback can be very useful in achieving insight and control, from the patient's point of view.

"If an anorexic or bulimic patient goes to therapy, will they usually be cured?"

There are numerous success stories. Maybe your family, or you, or someone you care about, could be one of those success stories!

But you have to keep in mind that these eating disorders are

nothing less than life-threatening illnesses. Just like psychological problems can cause a person to do serious physical damage by attempting suicide on the train tracks, psychological problems that cause eating disorders are equally serious.

There are simply no statistics that have been reported, as yet, regarding how well many patients do after entering into specific types of therapy. It can be safely said, however, that patients who do not enter into some sort of therapy have a much worse prognosis than those who do go for help, or those whose families bring them for help.

What is the answer, then? There is no definite answer. But doing something constructive is always a better route than giving up. In this type of situation, the most constructive thing to do is reach out for help. Someone is out there who can do a great deal of good for the anorexic, bulimic, bulimarexic, and the family, as well.

You can refer to the back of this book for agencies and organizations that exist to help give more information and support than can fit inside this one guide.

PART X

EDUCATIONAL/SELF-HELP PROGRAMS

Even if you or someone you care about is involved in treatment, you may find that you want to be part of an organization of people who are also taking steps towards a cure. Whether you are currently in treatment or not, the self-help or educational

group can be for you.

There are self-help groups and educationally oriented groups located throughout the nation, and they have thousands and thousands of members. Members are able to participate in conferences and local groups, write in for help to an organizational newsletter, and receive an enormous amount of moral support from the organization.

Members can also make new friends, and reach out beyond the tight family system that can be so difficult for many anorexics, for example. This type of contact can help a patient get closer to a future cure.

The questions most commonly asked about self-help groups is if they are good and if they are local.

Those two questions just cannot be given a blanket answer. There are national self-help groups, and local groups, as well. You can refer to the back of this book, and to your local social service agency, library, or youth and family service organization to find out if there are local groups near where you are.

Joining a self-help group can be the first step toward reaching out for other types of treatment and help, and should be encouraged. After all, the term self-help means that the group has confidence that the anorexic, the bulimic, and the bulimarexic can take control over helping herself, or himself.

PART XI

THE QUESTION OF SEX

"Do males ever become bulimic, anorexic, or bulimarexic?"

Absolutely. Although the vast majority of people suffering

from these eating disorders are female, there are cases of male patients, as well. At this point in America, it seems that there are about 9 female suffers to every 1 male victim.

Male patients demonstrate the same basic symptoms as the female population. It is possible that there are male patients who are not included in the ratio of 9:1 females as opposed to males because doctors are not alert to the possibility that males could be suffering from the disorder. This may or may not be true, but it does seem that the diagnosis is achieved faster in the case of females than in that of males.

Part XII

A FINAL POINT ON HISTORY

"Is our American society the only one or the first one to have these eating problems?"

Do you remember reading about how the Romans would eat and eat and eat and then purge themselves, so that they could eat again? It is clear that food disorders have been part of human society for thousands of years, if the history of mankind has been written with even a small degree of accuracy.

However, the first clinical reference to diagnosing a person as a victim of such a disorder is found in the 17th century. There have been cases that have been identified ever since. However, American society places a premium on being thin. There are the social and often destructive factors that have become part of the fabric of our current society, and those factors are more evident in some cultural groups than in others. You already know

the specific aspects of the socio-economic factors from reading that section of your guide.

Therefore, it can be said that the men and women suffering this disorder are more numerous now, in the United States, because of the numerous social and economic factors that have been noted earlier. However, it cannot be said that the United States was the first or only nation to produce people suffering from anorexia, bulimia, or bulimarexia. France, England, Rome, and the Asian countries, to name just a few, have also produced their share of the treatment population over time.

Summary: A Note to the Reader

If you have read this guide from the front to back, you have just absorbed a great deal of information. You may forget some of the things you have just read, and that is to be expected. You can keep on using this guide as a reference, to bring you up-to-date on this problem that is actually taking the lives of people we know and love.

This guide was not intended to make you an expert. You are not supposed to be the one who saves your friend or your relative. That friend or relative has to be part of the effort.

You can share this guide with your friend or the person you care about, and you can build a relationship that is based on information, instead of anger and confusion. When you can cut down on the anger and confusion, the best of all possible things can happen: the person you care about can begin to see that life may be worth living, and that changing certain behaviors might be

part of making life worthwhile. You can be a part of that process, so long as you keep in your heart that the best thing you can do is be there to listen, and to share what you have found out here: that there is help close by.

FINAL CLOSING NOTE

This resource has been developed to offer basic information to lay readers. Answers are not necessarily clinically comprehensive in every case, since the target reader population is not professional. Readers are urged to pursue further professional information and support, and to understand that this guide serves as a foundation for understanding.

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CHAPTER V

ROUTES OF DISTRIBUTION

Introduction

One of the best ways to educate is to raise questions, and to direct the student of the lesson to pursue more answers on his or her own. That makes it possible for the student to become an active participant in gathering and assessing information.

The guide, Everything You Always Wanted to Know About Anorexia and Bulimia, But Were Afraid to Ask, has been constructed with that approach in mind. The purpose is to inform, stimulate interest, and help the reader connect with the best possible local or national resources for further information or support. Given that the readership could range from people who simply want to know more, to people who are intimately involved with one or more of the disorders covered in this study, it is necessary to consider the nature of more than just the content of the book.

The effectiveness of a written piece of work is based on two factors: the content, and the distribution. The most information-packed document will be pointless if it fails to reach the right audience. So the question is not just one of achieving distribution, but of targeting that distribution so as to assure that the three basic goals are achieved: to inform, prevent, and identify, so that treatment can be pursued if necessary.

There are a variety of distribution sources that will be included in the marketing plan for this public information document. The list below represents a range of those distribution sources, but the final list will not be limited to those noted below. It is likely that other sources will emerge as the original list is contacted and notified that the publication is available for distribution to the public.

PUBLIC SOURCES

Public organizations would include, but would not be limited to, the following organizations.

- ** Intake Offices in Department of Mental Health Buildings
- ** Hospital intake offices
- ** Out-patient Mental Health clinics in schools, etc.
- ** New York City Public School system
- ** The Board of Cooperative Educational Services (B.O.C.E.S.)
(Nassau County; Western Suffolk; Eastern Suffolk)
- ** Division for Youth (DFY) direct-funded programs in N.Y.S.
- ** Department of Social Services offices
- ** Individual school districts throughout Nassau and Suffolk and Queens: contacted through school nurses and school superintendents
- ** Police Departments, Nassau, Suffolk, and Queens (Juvenile Aid Offices, referred to as JAO).
- ** Department of Probation Intake Offices: Juvenile
- ** County and City Youth Bureaus: City, Suffolk, and Nassau

PRIVATE SOURCES

- ** Red Cross
- ** Private Contract Agencies for Youth and Families, including Catholic Charities, the Jewish Board of Guardians, Drug and Alcohol Abuse programs, Berkshire Farm Center and Services

for Youth, Residential treatment programs, such as-
sociated with the Family Court, and others

- ** Family Court Law Guardians
- ** Private medical practitioners
- ** Private psychotherapists
- ** Private psychiatrists
- ** Child Care Organizations, such as the School Age Child
Care Organizations emerging locally throughout New York
State and other states
- ** Private Clinics for mental health
- ** Schools K-graduate school
- ** Dentist organizations
- ** Teacher organizations
- ** School Administrator organizations
- ** Self-Help Groups, e.g. B.A.S.H. (Bulimia/Anorexia Self-
Help)

Summary

The procedure for distribution would essentially be a combination of direct mail, public speaking engagements, and advertising through professional journals and newsletters. The specific steps of this process would be determined in conjunction with professionals who have had experience and success in reaching specific target populations in need of therapeutic intervention or prevention.

In addition, all professional groups involved in the treatment, identification, and prevention of eating disorders would be notified of the publication of this guide. ■

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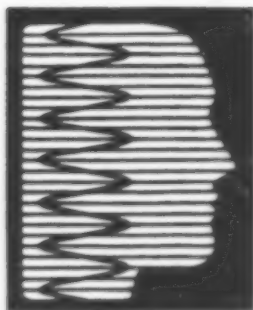
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APPENDIX A



BIOFEEDBACK & PSYCHOTHERAPY CENTER

Marc Zimmer, Director
1 Sunrise Plaza
Valley Stream, N.Y. 11581
(516) 825-5006
(212) 204-0660

SURVEY QUESTIONNAIRE

(PLEASE FILL OUT PERSONAL DATA BUT DO NOT INCLUDE YOUR NAME IN ORDER TO MAINTAIN CONFIDENTIALITY. If you wish, at the end of the form you may include your name if you wish a personal response to your question.)

AGE: _____ SEX: _____ RELIGION: _____ EDUCATION: _____

PROFESSION/OCCUPATION: _____ GEOGRAPHICAL LOCATION: _____

IN WHAT WAY OR CAPACITY ARE YOU FAMILIAR WITH EATING DISORDERS? _____

.....

BELOW YOU WILL FIND SEVERAL CATEGORIES RELATED TO EATING DISORDERS (ANOREXIA AND BULIMIA). IF YOU HAVE ANY QUESTIONS RELATED TO ONE OR MORE OF THESE AREAS, PLEASE WRITE THEM DOWN UNDER EACH HEADING. YOUR QUESTIONS CAN BE RELATED TO YOURSELF, FAMILY, FRIENDS, OR SIMPLY GENERAL CLINICAL CONCERNS. THANK YOU FOR YOUR HELP.

A) PHYSICAL (PHYSIOLOGICAL):

B) PSYCHOLOGICAL:

C) FAMILY:

D) ENVIRONMENTAL FACTORS:

E) MEDICAL ISSUES:

F) SOCIAL FACTORS:

G) HABITS AND BEHAVIOR:

H) TREATMENT APPROACHES (Psychological and Medical):

I) HISTORICAL PERSPECTIVES:

J) EDUCATIONAL/SELF-HELP:

K) SEXUAL:

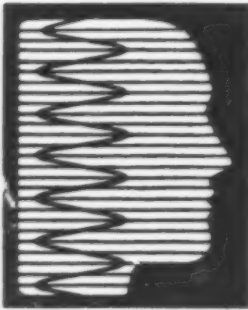
QUESTIONNAIRE, con..

L) OTHER (Any area not included on pages 1 or 2, or additional questions if you ran out of room):

Again, thank you for your cooperation and assistance.


- Marc Zimmer, A.C.S.W.

APPENDIX B



BIOFEEDBACK & PSYCHOTHERAPY CENTER

Marc Zimmer, Director
1 Sunrise Plaza
Valley Stream, N.Y. 11581
(516) 825-5005
(212) 204-0680

Dear

At the present time, I am seeking the assistance of many individuals for the purpose of preparing a document that will attempt to provide extensive and useful information concerning eating disorders to a wide variety of readers. While many books have been written on the subject, they are often too specific in one perspective, or too clinical for the lay public. Also, they rarely deal with the specific questions and concerns of many potential readers.

I am in the process of preparing a document in a question/answer format that will provide the public, as well as the clinical community, with a useful resource for the field of eating disorders. It will be written in such a way that it may be understood by all. As part of the initial preparation, I am sending the enclosed survey form in order to gather the most frequent questions and concerns regarding eating disorders. Among those I am surveying are patients, families of patients, physicians, and other clinicians, teachers, clergy, members of helping organizations (i.e. Red Cross, etc.), and other individuals who may be interested.

Upon return of the surveys, as many questions as possible will be addressed and included in the document. If you need additional survey forms, please feel free to contact me. Thank you in advance for your help in this task.

Yours truly,

Marc Zimmer, A.C.S.W.
Director

APPENDIX C

ADDITIONAL QUESTIONS RAISED BY RESPONDENTS

A = Anorexia

B = Bulimia

Is A/B contagious?

What ages is A/B most prevalent?

Can adults get A/B?

How does B affect the teeth, the gastrointestinal system, hair, skin?

Do I need medical treatment?

Do I need family therapy?

Can I treat myself without help?

Which medical specialty should I see first?

If my sister has A/B, should I tell my parents?

Can drugs help me?

How can I learn to relax - reduce anxiety?

What is the best way to handle fear?

Will A/B affect my height?

Is knowing my psychological diagnosis important for me to know?

Should I tell my parents what they do that bothers me?

Should I move out of my parents house?

Should I fast?

Can laxatives hurt me?

Are diuretics dangerous?

Why am I tired physically but hyper mentally?

Do cold hands and feet mean anything?

When was A/B first diagnosed?

How can I limit my food consumption when at affairs?

Where can I receive help - organizations?

Why do I sometimes feel very sexually active and then sometimes I don't want sex?

Street drugs help me feel better but I eat more and throw up, or don't eat at all?

Should I work with a male or female therapist?

How do I find a good therapist to help me with A/B?

Should I physically exercise and how much?

Is there a cause for A/B?

Will my children learn my A/B behavior?

Will throwing up or not eating hurt my pregnancy?

What vitamins should I take?

Will I get my period back?

Will I be able to become pregnant and have children?

How can I stop my friends from putting pressure on me to be thin or vomit?

Will my ability to concentrate return and improve?

Did my parents make me A/B?

Is A/B a mental or physical disorder?

Should I confront my A/B daughter about having A/B and going for help?

Should I drink diet soda, gum, food?

My only love is for food, but I also hate it. Is this normal?

Why am I frightened to go out of the house?

Do I need group or individual therapy?

Why do I always feel nervous?

What is the criteria for diagnosis of Anorexia?

What is the criteria for diagnosis of Bulimia?

What is the difference between A and B?

Why can't I accept compliments?

How does Biofeedback help - (impulse control)?

Is A/B found in other countries?

Is A/B more prevalent in the rich?

Is A/B more prevalent in certain religions and why?

How much fat should I have in my diet?

Do men get A/B?

Why do more women get A/B?

Which is worse, A or B?

Why do I drink so much liquids?

Why is my urine smelling bad?

Why are my fingernails so bumpy?

What are the ages for A/B?

Why do I have trouble sleeping?

What kind of doctor or therapist can treat A/B?

Why is A/B so popular - Many people I know have it?

When did A/B first begin in history?

Will I be able to have children if my period returns?

Are pimples and bad complexion a symptom of A/B?

Is bad breath a part of A/B?

How long does therapy take?

How much does treatment cost?

Is blood pressure affected by throwing up?

Is the condition beyond their control that they do not know their bodies are not functioning properly?

Can death occur because of these disorders?

If you are cured, could the disorder reoccur?

Why do people become A/B if they are thin?

Does the pain or affliction bother them mentally?

What if people say "You look too thin or skinny"?

Can those with A/B accept compliments?

Why are people with these disorders hiding it?

Can't the family see this person is acting in a way that weight loss is evident?

Family help should be the start and first direction, shouldn't it?

Watching T.V. commercials showing Diet Pepsi, Lo Cal and Weight Watcher's - why are only thin models shown?

Medication (diuretics and laxatives) should be prescription only, especially for minors.

Why have American put so much emphasis on weight consciousness?

If people with these disorders did not socialize with the so called beautiful people, wouldn't they be more careful (healthy)?

Do they hide the medication and symptoms from their family?

Do they act irrational? When?

Do their grades drop below level?

What kind of treatment is needed?

How long is medical or psychological treatment?

Should friends interfere and warn them of their condition and try to help or tell them to seek mental help?

Do they feel they have to keep watch of their weight to attract the opposite sex?

I have a friend who is very thin even though she was a little heavy at one time; could she have A/B?

Is there any truth to the fat cell theory?

Can you tell anyone has A/B by their physical appearance?

What psychological problems could cause a person to become A/B?

Could any member of the family foresee this happening to others in the family?

Could a person's environment cause these disorders?

Is there a permanent cure for A/B?

Could peer pressure cause A/B?

Could irregular eating habits cause A/B?

Could depression or anxiety cause A/B?

Could an appetizer increaser cure A?

Could these disorders be inherited?

Could a person educate themselves into a cure?

Could the lack of sex cause A/B?

Does A/B hinder or stop you from having children?

Does A/B make you not care about the rest of your life?

Are the signs and symptoms obvious to people close to you?

Is it most common in New York?

What medical treatment is there?

What groups of people usually get these disorders; rich-poor, black-white?

What age groups are mostly affected by A/B?

What specific things does Bulimia do to you, physical and what period of time do these things take to happen to your body?

What are the major causes of A/B?

How can the family help?

Do people in certain careers or professions have A/B?

What are the drawbacks to medications that might help with A/B?

What are the reasons for these disorders to be at such high levels in the U.S.? Are they higher in any other country?

Would it help to educate young children about A/B or prevention?

What are the psychological differences between an anorexic and a bulimic?

Do they look sick?

Do they socialize or are they introverted?

Is there a higher incidence of street drug or alcohol abuse with A/B victims?

Does their job affect them? Stress?

Why do they feel food is disgusting?

Why are they such fussy eaters?

Why is it prevalent now as opposed to 60 years ago?

Does self-help help them the most?

Do they not want to have sex?

Can you see any physical change in a person's shape, face or skin?

Does too much or not enough money affect this?

Does a happy or divorced home have an effect?

Does living conditions have any effect such as locality or apartment opposed to houses?

Can you detect a change in a person's habit or behavior?

Do they have a small appetite or none at all?

Does this come from a background of similar illnesses or can this happen to anyone; any predisposition?

Are there any courses to help a person deal with A/B?

Is this more common in males or females? Why?

How do people actually see themselves obese and be so thin?

Does therapy begin from the home or clinic first and then bring in members from the family?

Once A/B is cured is it likely to return? What brings it on again?

I have a friend who is a Manic-Depressive. She seems to have Bulimia. Are these two disorders correlated?

Do people who live in cold climates eat more?

Is a person who stays home more likely to eat more?

Is over-eating inherited?

If you have a frustrated sex life, is there a tendency to over eat?

What are the initial signs that are visible to either disorder before it reaches a chronic stage?

What permanent damage can occur?

Can A/B recognize the need for psychological treatment?

Is it a form of self-hate?

Is it a death wish?

Is it a manifestation of inadequate family life?

Is there a bacteria associated with A/B?

What causes the throwing up of the food?

What effect does A/B have on parents?

How far back in a child's life do courses of rejection and food go?

What role can friends play in the cause or cure of A/B?

What does school pressure/work play with A/B?

What effect does biofeedback play?

Do anorexics have any sex drive?

Is it a way of gaining needed attention from people close to the person?

Can A/B cause dehydration?

Is family pressure to succeed too much for A/B's to handle?

Should an eating disorder patient go to a psychiatrist or a medical doctor for treatment? Which one first?

Can self-help programs help eating disorder victims?

Are A/B repressing social pressure?

What can the general public do to prevent A/B?

Is it true most of the eating disorders are caused by stress?

How can biofeedback be used in treating A/B?

Can treatment be given even in extreme cases?

Why don't they have more information available to the public on A/B?

What percent males vs. females have A?

How would this individual react to problems of other family members?

Is A/B more an urban or suburban problem?

Treatment - Would a liberal or conservative approach be more effective?

When was the first case known and where? Who? What was the outcome?

Where can one receive more information and guidance on A/B?

Can you define the psychological profile of the see-saw fatty?

Is A/B hereditary?

Is group therapy recommended?

Is the one to one approach more effective?

If early detection of A/B is possible, what is the best approach to use so that you do not add to the problem?

What type of personality is most apt to develop A/B?

Does educational background play any part?

Do childhood eating habits have anything to do with whether or not someone will become anorexic?

Are schools talking to students about these problems in an effort to prevent them?

Do certain religions have higher incidences of A/B?

Can sexual problems cause Anorexia?

Does A/B occur to a specific sibling - 1st, 2nd - 3rd?

How much weight can a person lose, before it becomes dangerous?

Will an A/B eat in public?

Where can you get help? List of Agencies.

Does one lose the desire for sexual relations?

Is there ever a cure for A/B?

Are there biological traits?

Is this a family or individual problem?

Why is there a psychological distortion in the perception of body size/weight?

Can behavior modification be used to change this behavior?

Do different age groups affected by A/B share a common cause relationship or do motivating factors change as patients grow older?

Are any body type endomorph, ectomorph, mesomorph represented in greater numbers and more prone to eating disorders?

Is it true that Anorexia eventually becomes a disorder that you cannot control physically, i.e.: can't control your body's function, i.e.: vomiting?

What are the long range physical results of A?

Are there any habits or behaviors that can be identified before the onset of A?

Is intravenous feeding the only medical treatment?

Are they scared of the opposite sex and of being touched?

If you know someone has A, what can you do to help them?

Does it have anything to do with depressive disorders?

Is there any metabolic differences for people with A/B?

Is A and B separate and distinct disorders, or are they opposite on the same continuum?

Is there any differences in brain chemistry?

Do people who are more extroverted or introverted get A/B?

Are there any known causes that trigger A and if so, what are they?

What is the A profile?

What is the B profile?

What is the medical community doing to address this issue regarding diagnosis, treatment and cure?

Which is the first medical doctor to see or suspect A/B, re: blood tests, etc.?

Are there nutritional approaches to A/B, i.e. - megavitamins?

What treatment approaches seem to be the most effective?

When was it first recognized that A/B is a serious disorder?

Where is most of the research being conducted?

Is there any support that compulsive runners are latent A's?

What environmental factors contribute to A/B?

Must one seek professional help if a cure is to be successful or can one do it by themselves?

What are medical causes or etiology for weight loss and gain?

Is surgery successful for obesity treatment?

Why do A/B drink so much coffee, tea, water and other liquids?

Does A/B increase or decrease sexual pleasure, i.e.: orgasm?

Do M.D.'s look for sign of A/B?

Are M.D.'s knowledgeable with regard to treating eating disorders?

How does society view A/B?

What are the dominant characteristics historically?

What educational approaches are successful?

How does the person view themselves?

What do they wish to accomplish?

Is there any level (stage) of the disorder that allows for more help than at other stages?

What stage, if any, is the turning point and treatment becomes ineffective?

How do they manipulate and deceive others?

Is treatment difficult?

What is the average time for treatment?

Can a person with A return to looking normal?

Is the disease ever actually due to a physical problem?

Can A/B occur when there aren't any psychological problems to speak of?

Is it more frequent among divorced families?

Does it occur more often now that our society is so impressed by thin people?

Which type of treatment has been more successful?

Can a trauma such as a severe accident or death bring on an eating disorder?

Is Anorexia a self-destructive act or an act of attention getting?

How do anorexic people stay healthy?

Are all anorexics fat to begin with?

How do therapists break through to a person with A/B?

Is it true that people with A do not allow food to touch their lips, do not sit on foreign toilet seats, and are extremely neat?

Can being labeled a "fag", "nurd", "slut", or any other name effect a person's eating patterns?

Are there classes that a person with an eating disorder can go to like AA or WW?

What is the percent of Male - Female

A-
B-
A/B-

As more women than men get A/B, are female therapists more effective?

What make B's throw up physically?

I would like to know when you become anorexic is it that you can't hold down food physically or mentally or they just refuse to eat?

In Bulimia, after the excessive eating, does your body actually need so much food?

Is the person (A/B) doing this subconsciously or is it intentional?

When does a victim of A/B need medical attention?

Can the patient carry on a normal way of life, i.e.: work, school, socialization?

Once a person stops being anorexic do they go through withdrawal symptoms - psychologically and physically?

Does the person suffering from this disease reach out for help themselves or are they usually forced to get help?

Any irreversible medical damage?

Do A/B seek out each other as friends?

What behaviors at a young age might be a clue to a person becoming A/B?

Is a strong willed person apt to be a candidate for eating disorders?

Should the patient stay with one therapist for help or seek more than one?

Does everyone who is A/B lose their period? When does it return?

Why does the anorexic really not want outsiders to know about themselves?

Do the A/B habits continue after treatment is terminated?

Does this usually affect one or members of a family?

Would it help to have all of the family members attend family sessions or just the parents and patient?

How long can the human body tolerate the physical abuse of A/B?

Do anorexics ever maintain a normal weight?

Is confusion a common state of A/B? At what state? Why?

What is the major significance of money to many B's?

Why is exercising so important to A/B's?

Is hyperthyroidism a common part of A/B?

Is male impotency common with A/B? Can it be cured?

Does Bulimia have a tendency to reoccur like depression?

Do people die from A/B and why? What is the most common diagnosis?

How do A's see themselves in the mirror?

How can one distinguish between a very thin person and an anorexic?

In which cultures is A/B very low/high? Why?

What does eating provide beside nourishment?